

# PMP HCAI & OCF Guide

December 2014

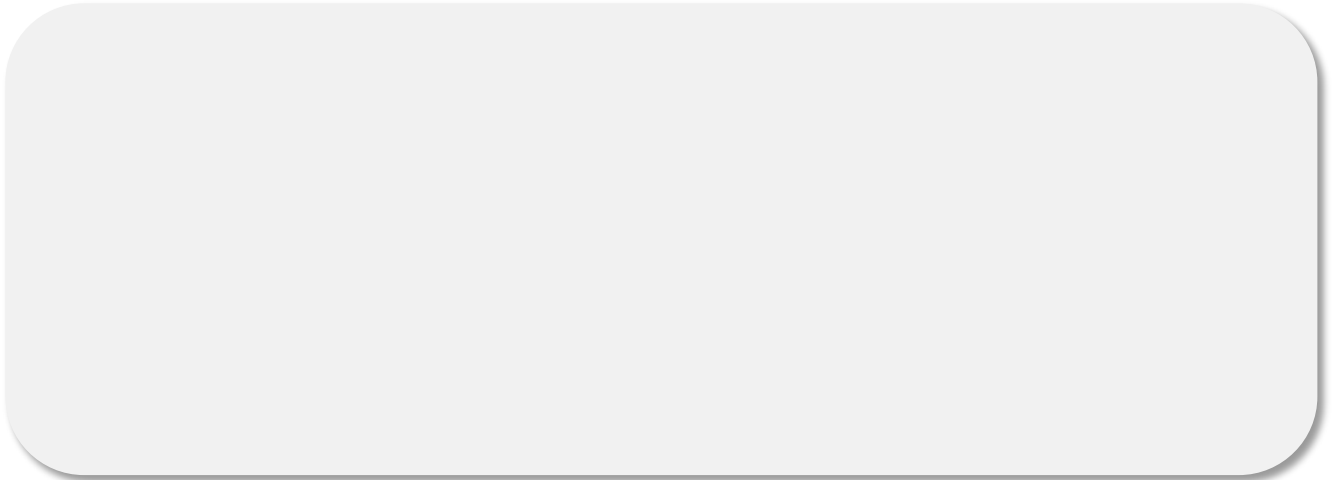
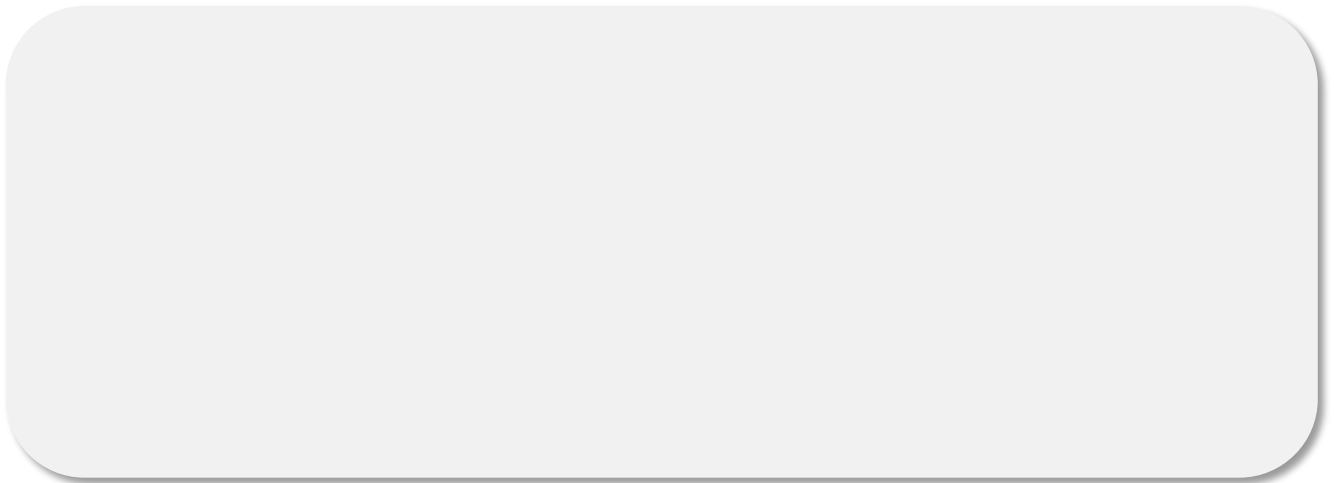
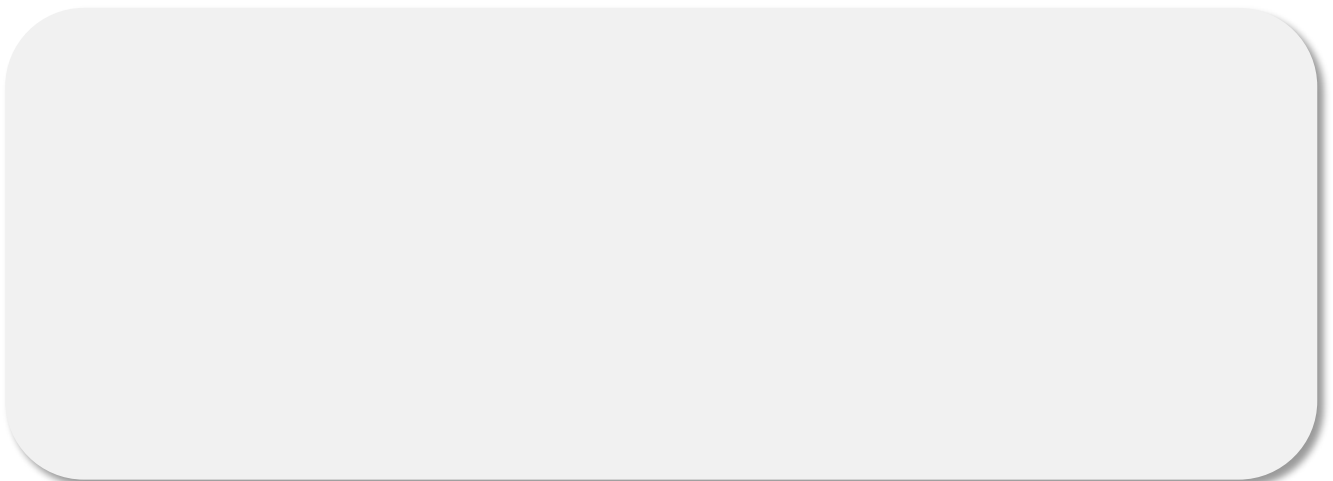


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## Contact Information

A large, empty, light gray rounded rectangular box with a subtle drop shadow, intended for contact information.A large, empty, light gray rounded rectangular box with a subtle drop shadow, intended for contact information.A large, empty, light gray rounded rectangular box with a subtle drop shadow, intended for contact information.

## What is HCAI?

Health Claims for Auto Insurance (HCAI) is part of an ongoing effort to improve the delivery of health care benefits to Ontarians injured in automobile collisions. HCAI seeks to automate the exchange of standardized health claim information between health care providers and insurance companies. An initiative of Ontario auto insurers, HCAI has been developed in consultation with the Financial Services Commission of Ontario (FSCO), health care provider associations and other stakeholders in the auto insurance system.

### About HCAI

HCAI is an electronic system for transmitting auto insurance health claim forms between insurers and health care providers in Ontario. The HCAI system is administered by Health Claims for Auto Insurance Processing (HCAI Processing), a not-for-profit organization.

The primary goal of the system is to provide timely, accurate data to monitor the auto insurance system in Ontario.

The HCAI application enables health care facilities that treat people injured in automobile collisions to transmit various Ontario Claim Forms (OCFs) to insurers electronically. Insurers then electronically adjudicate the OCFs.

Some of the regulatory reforms the Ontario Government has introduced to Ontario's auto insurance system impact the OCFs that are submitted using the HCAI system.

As of September 1, 2010 all new submissions for treatment, assessment and invoicing must be submitted by health care facilities using the revised forms. The revised OCFs are:

- OCF-18, Treatment and Assessment Plan
- OCF-23, Treatment Confirmation Form
- OCF-21B/C, Auto Insurance Standard Invoice

### What are ICD-10 and ICD-10-CA?

The *International Statistical Classification of Diseases and Related Health Problems – Tenth Revision (ICD-10)* is an international standard for reporting diseases, injuries, and causes of death developed by the *World Health Organization (WHO)*.

ICD-10-CA is an enhanced version of ICD-10 developed by Canadian Institute for Health Information (CIHI) and is the classification facilities use to record problems, diagnoses, symptoms and other conditions necessitating contact with health care providers.

## What is CCI?

The Canadian Classification of Health Interventions, referred to as CCI, was developed by CIHI. It is a comprehensive list of codes for diagnostic, therapeutic, and support interventions.

## What are GAP Codes?

GAP codes were developed by Insurance Bureau of Canada in conjunction with automobile insurers and health care providers. They were designed to cover those items billed to automobile insurers by providers that are not covered by the Canadian Classification of Health Interventions (CCI) or may be more efficiently coded using the GAP codes.

Items that may fall outside of the realm of a medical / rehabilitation procedure, intervention, or service, are coded by providers using GAP codes. These include: goods, supplies, assistive devices, mileage, travel time, pre-approved framework reimbursement codes, telephone consultation between the Insurer Examiner and the proposing health practitioner and session codes. These GAP codes are also used to identify various types of assessments and examinations including: DAC assessments, Insurer Initiated Examinations, Practitioner Initiated Examinations, Pre-Claim Examinations, and Rebuttal Examinations.

The hierarchical coding structure of GAP codes is similar to CCI codes to allow summarizing at various levels. GAP codes can be immediately distinguished from CCI codes by the leading alphabetic character, as all CCI codes begin with a numeric code.

## What is FSCO?

The Financial Services Commission of Ontario (FSCO) is an agency of the Ministry of Finance that regulates certain financial services sectors conducting business in Ontario. FSCO and HCAI work collaboratively on various initiatives to fight fraud in Ontario's auto insurance system.

## How are HCAI and FSCO Connected?

An initiative of Ontario auto insurers, HCAI has been developed in consultation with the Financial Services Commission of Ontario (FSCO), health care provider associations and other stakeholders in the auto insurance system. Healthcare facilities must be registered with HCAI in order to submit Ontario Claim Forms (OCFs).

FSCO's legislative mandate is to provide regulatory services that protect the public interest and enhance public confidence in the sectors it regulates. FSCO regulates the insurance sector and healthcare facilities must be licensed with FSCO in order to be paid for OCF21s that are submitted through HCAI.

## Government Efforts to Curtail Fraud in Auto Insurance

From 2006 to 2010 Ontario experienced a substantial increase in automobile insurance claims costs. The significant increase in costs was primarily attributed to increases in Statutory Accident Benefits (SABS) claims costs.

In the **2013 Ontario Budget**, the government committed to take further action to address fraud in the auto insurance sector. Among other announced measures, the government signalled its intention to give FSCO the authority to license health clinics that invoice auto insurers and regulate their business and billing practices.

**Bill 65, Prosperous and Fair Ontario Act** established the legislative framework for FSCO to license and regulate Service Providers. Once licensed, a Service Provider will be able to continue to be paid directly by an auto insurer for certain services (“listed expenses”) invoiced through HCAI.

## How FSCO is Regulating Service Providers

The Financial Services Commission of Ontario (FSCO) is responsible for the licensing and regulation of the business and billing practices of service providers. As of December 1, 2014, service providers must be licensed in order to receive direct payment from auto insurers for goods and services (listed expenses) provided on or after December 1, 2014, in connection with the SABS.

Typically, service providers are health and rehabilitation clinics, as well as providers of assessments and examinations.

Service provider licences are issued at the business or legal entity level. This means that only one licence is needed for all of the facilities, branches or locations operated by the same service provider that provide specified goods or services (listed expenses) to statutory accident benefit claimants.

For the purposes of applying for a licence, FSCO classifies service provider businesses according to the legal structure of the business.

- Sole Proprietorship
- Partnership (General and Limited)
- Corporations

## Provider Licences

Beginning December 1, 2014:

- A service provider will need a service provider licence to receive direct payment from automobile insurers for these listed expenses.
- Automobile insurers will not be allowed to pay a service provider for listed expenses in connection with goods or services provided on or after December 1, 2014, if the business or legal entity does not hold a service provider licence.



**Note:** Unlicensed service providers will still be required to submit all OCF forms through the HCAI system, but will not be able to receive direct payment from auto insurers. Unlicensed service providers must seek payment from their claimants, who in turn, will seek reimbursement from their insurer.

## Submitting OCF21's – With or Without a Licence:

### Submitting OCF-21s and Getting Paid With or Without a Service Provider Licence

Whether or not they choose to pursue a Service Provider Licence, chiropractors will retain the right to treat auto insurance patients. FSCO has clarified how this change will affect service providers who choose not to become licensed. **Both licensed and unlicensed service providers will continue to complete and submit the Auto Insurance Standard Invoice (OCF-21) through HCAI.** Insurers will continue to record their adjudication decisions in HCAI for all invoice submissions from licensed and unlicensed service providers.

Reimbursement following submission of the OCF-21 will be different for licensed and unlicensed service providers:

- Insurers will pay licensed service providers directly on submitted OCF-21s in accordance with the SABS for goods and services provided on or after December 1, 2014
- Insurers will be prohibited from paying unlicensed service providers directly on OCF-21s for goods and services provided on or after December 1, 2014. Unlicensed service providers are to:
  - Collect payment directly from the claimant.
  - Provide a hard copy of the HCAI-validated OCF-21 to the claimant for submission to his/her insurer.

## PMP HCAI Electronic Data Interchange

The PMP HCAI interface was created to allow PMP users to send OCF forms and claims from within their PMP programs directly to the HCAI system. This is completed without the need to access the HCAI system. The program is intuitive and has an easy-to-use interface.

Here are just a few of the benefits for using the PMP HCAI interface:

- information transfers from the patient file to OCF forms and then all details copy to additional reports, reducing the amount of time required for completion of subsequent forms
- OCF forms & invoices are created in PMP and do not need to be duplicated on the HCAI website
- Claims and forms are made and stored locally, on your computer
- Claims and forms are created without access to the internet. An internet connection is required only to send completed forms.

In order for PMP users to use the PMP HCAI interface for electronic submission of auto insurance claims and forms you must first have:

- Registered with HCAI and selected your submission method as PMS
- Downloaded and install the PMP HCAI module.

## Using the HCAI System

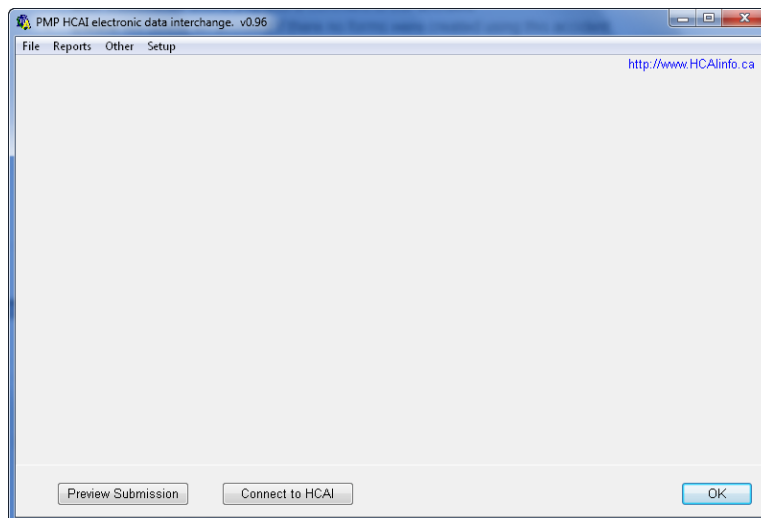
The HCAI system, accessed through the internet, [www.hcai.ca](http://www.hcai.ca), is used for updating facility, payee, and practitioner information.



The screenshot shows the HCAI Sign-In page. At the top, there is a header with the HCAI logo and the text "Health Claims for Auto Insurance". Below the header, there is a "HCAI Sign-In" section. On the left, there is a "User Name:" field and a "Password:" field, both with input boxes. To the right of these fields is a "SIGN-IN" button. Below the fields, there are three links: "Sign-in help", "Forgot your password", and "Register a facility". On the right side of the page, there is a text box explaining that HCAI is an initiative of Ontario auto insurers and provides information on how to access the system. At the bottom, there is a footer with the copyright notice "© 2009 Health Claims for Auto Insurance Processing" and a link to the "Privacy Policy".

## Using the PMP HCAI Interface

The PMP HCAI interface, accessed from a desktop icon named **PMP HCAI**, is used for submission and retrieving adjudication responses of OCF forms and claims electronically.



The screenshot shows the PMP HCAI electronic data interchange window. The title bar reads "PMP HCAI electronic data interchange. v0.96". The menu bar includes "File", "Reports", "Other", and "Setup". The main area is a large, empty white space. In the bottom right corner, there is a URL "http://www.HCAInfo.ca". At the bottom of the window, there are three buttons: "Preview Submission", "Connect to HCAI", and "OK".

# Setup Procedure for using PMP for HCAI

## Changing your HCAI Submission Method

This procedure will change your submission method to allow you to submit OCF forms and claims directly to HCAI through the internet using the PMP HCAI interface.

Access the HCAI website from your internet browser at [www.hcai.ca](http://www.hcai.ca) and login.

Click the **Manage** tab at the top of the screen and click **Facility Management** on the lower tabs.

Scroll down the screen until you locate the **HCAI Submission Method**.

Select **Yes** to *\*PMS Integration*.

Type **PMP** into *\*PMS Vendor*:

Type a user name into the *\*PMS User Name*: field.

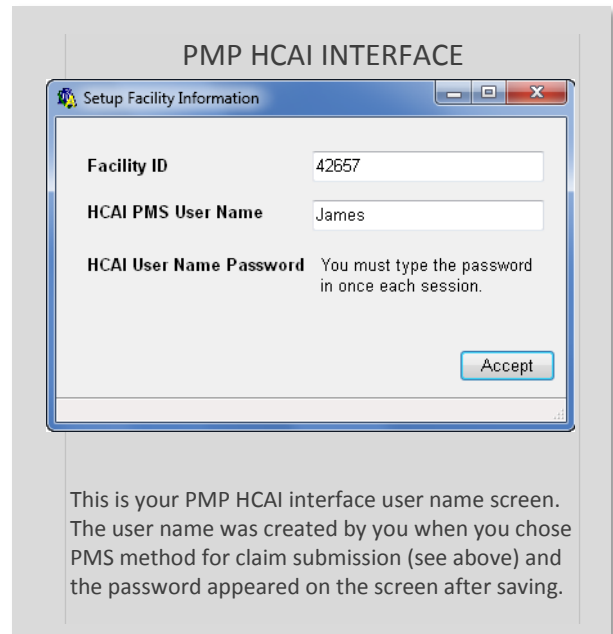
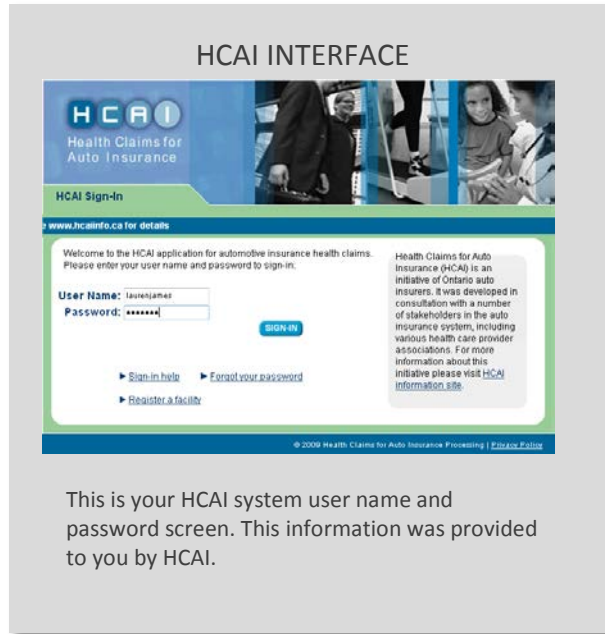
Click **Save**. Your PMS Password will now appear on the screen. Write this password down.



*Your password is case sensitive.*

## User Names and Passwords

PMP HCAI interface users will have two user names and passwords. One set for entering the HCAI system and one set for entering the PMP HCAI interface.



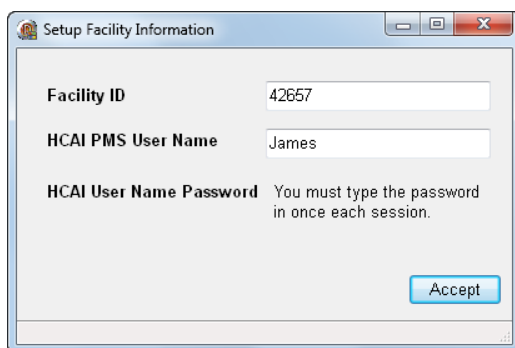
## Set Up for PMP HCAI

Now you will need to set up the Facility Information. This is a first time procedure only and will not need to be repeated.

Double click the **PMP HCAI** icon on the desktop.



This screen requires you to use the *PMS User Name* that you selected when you set up **HCAI Submission Method**, detailed on the previous page. Go to the **Setup** menu, **Setup Facility**. Input user name that you selected.



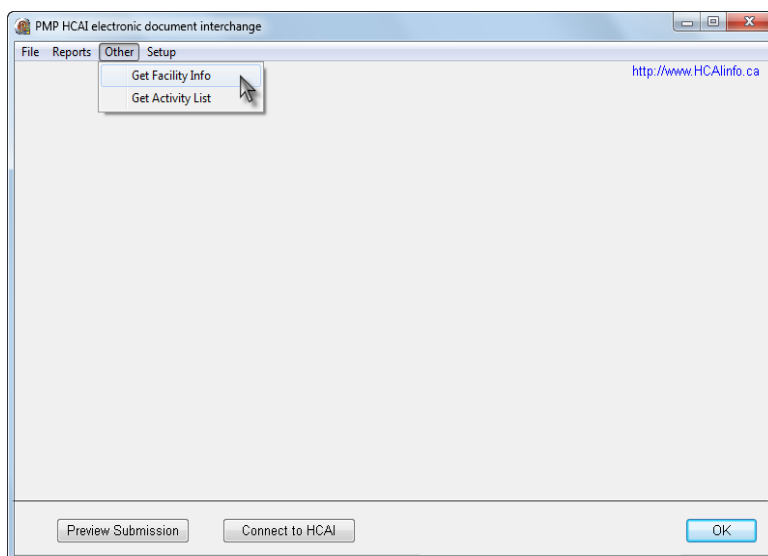
This is **NOT** the user name that you use to get into the HCAI system.

Click **Accept**.

If you do not know your **Facility ID** and **HCAI PMS User Name** they can be found on the **Facility Management** tab under **Manage** of the HCAI web portal, [www.hcai.ca](http://www.hcai.ca).

You can also reset your password in this screen.

Once you have input the Facility Information, go back into **PMP HCAI**. Go to the **Other** menu, **Get Facility Info**. This will communicate with HCAI and bring back Provider ID's which are required in order for practitioners to successfully submit OCF forms to HCAI.



You will be presented with a PMS HCAI password screen. This is your **PMS Password** that is or was given to you after selecting PMS as your submission method. This is different from the password for the Authorizing Officer.

This is **NOT** the authorizing officer password that you use to get into the HCAI system.

Type in your PMS password, note that it is case sensitive. Click **OK**.

To view or print your Facility Information report that details your facility and Provider ID's go to the **Reports** menu, **Facility Information**. This report is updated every time you select **Connect to HCAI** or select **Get Facility Info**. Click **Run the Report**.

Tue, 16 Dec 2014 **Facility Information** Page No. 1

|  |  |                            |                           |
|--|--|----------------------------|---------------------------|
| <b>Facility Name</b> PMP Department        |  | <b>Authorizing Officer</b> |                           |
| <b>HCAI Facility Registry Number</b> 42657 |  | <b>First Name</b> Lauren   |                           |
|  |  | <b>Last Name</b> James     |                           |
|  |  | <b>Title</b>               |                           |
|  |  | <b>Telephone</b>           |                           |
|  |  | <b>Fax</b>                 |                           |
|  |  | <b>Email</b>               | ljames@chiropractic.on.ca |

|                         |                        |  |
|-------------------------|------------------------|--|
| <b>Business Address</b> | <b>Service Address</b> |  |
| 20 Victoria St          | Service ALine1         |  |
| Mississauga ON          | Service ALine2         |  |
| M5C2n8                  | Service ALine2         |  |
|                         | ServiceCity ON         |  |
|                         | L0A 1L7                |  |

|                                       |                             |                                 |
|---------------------------------------|-----------------------------|---------------------------------|
| <b>Cheque Payable To</b> Lauren James | <b>Contact One</b>          | <b>Contact Two</b>              |
| <b>Payee Field Editable</b> True      | <b>First Name</b> Liz       | <b>First Name</b> Con2FirstName |
|                                       | <b>Last Name</b> Pridham    | <b>Last Name</b> Con2LastName   |
|                                       | <b>Title</b> Rep            | <b>Title</b> Mr.                |
|                                       | <b>Telephone</b> 4168604163 | <b>Telephone</b> 4168600857     |
|                                       | <b>Email</b>                | <b>Email</b> Rick@alpha.to      |

**FSCO License Details**

|                                   |                        |
|-----------------------------------|------------------------|
| <b>License Number</b> LicNo_42657 | <b>Type of License</b> |
| <b>License Status</b> Licensed    |                        |

**Provider Listing**

| First Name | Last Name  | Provider ID * | College **<br>Registration Number | Start Date | Date Last<br>Modified |
|------------|------------|---------------|-----------------------------------|------------|-----------------------|
| Albert     | Schweizer  | 819           | J222                              | MT         | 14-May-10             |
| Charles    | Winchester | 820           | 5896                              | DC         | 14-May-10             |
| Elizabeth  | Hurley     | 1111          | 122558                            | NT         | 19-Nov-10             |
| Joe        | OCACHIRO   | 1230          | DC-872346                         | DC         | 09-Mar-11             |
| Daniel     | Palmer     | 1248          | 1234                              | DC         | 09-Apr-11             |
| Benjamin   | Pierce     | 1835          | Hypnosis                          | OTH        | 10-Oct-13             |

\* Provider ID's are created by HCAI and are required by each practitioner in your facility for submission and treatment of patients on OCF's. To get Provider IDs go to the Other menu, Select Assign Provider ID's to PMP doctors. For every practitioner that does not have an assigned number in this list move to the right of the name and click Edit Dr. Click the drop down arrow to the right of Provider ID. The HCAI list of providers will appear with their Provider ID. Select the correct practitioner from the list and click Accept

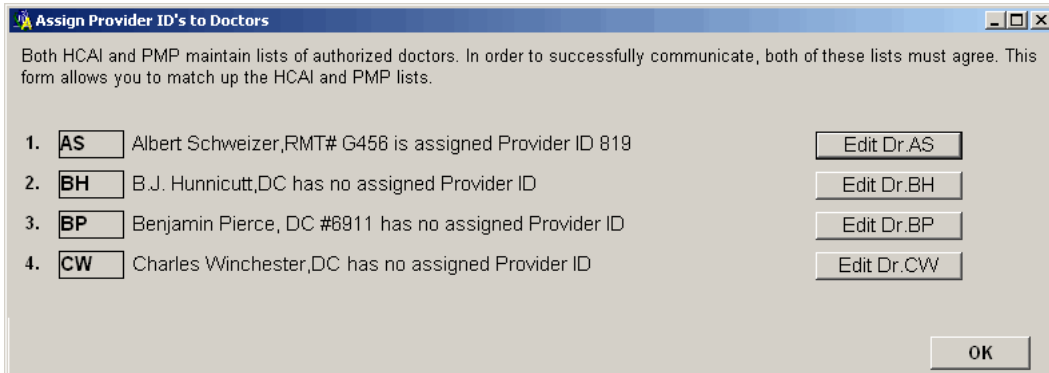
\*\* College registration number was created by PMP when the practitioner was added to your program. If a practitioner does not have an assigned registration number contact the support department.

## Assign Provider ID's to PMP Doctors

Provider ID's are created by HCAI and are required by each practitioner in your facility if they are submitting or treating patients on OCF's.

Go to the **Other** menu. Select **Assign Provider ID's to PMP doctors**.

For every practitioner that does not have an assigned number in this list move to the right of the name and click **Edit Dr.**

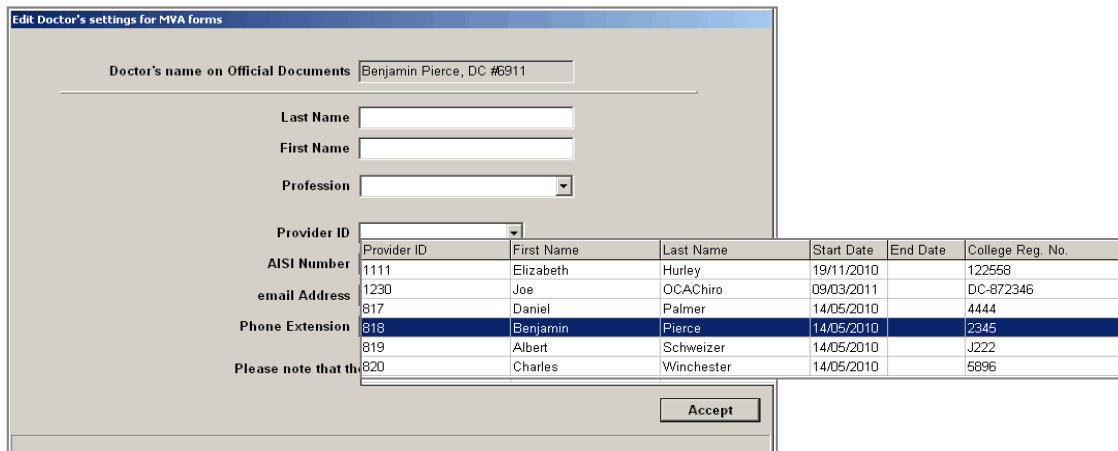


**Assign Provider ID's to Doctors**

Both HCAI and PMP maintain lists of authorized doctors. In order to successfully communicate, both of these lists must agree. This form allows you to match up the HCAI and PMP lists.

|              |  |   |
|--------------|--|---|
| 1. <b>AS</b> | Albert Schweizer,RMT# G456 is assigned Provider ID 819 | <input type="button" value="Edit Dr.AS"/> |
| 2. <b>BH</b> | B.J. Hunnicutt,DC has no assigned Provider ID          | <input type="button" value="Edit Dr.BH"/> |
| 3. <b>BP</b> | Benjamin Pierce, DC #6911 has no assigned Provider ID  | <input type="button" value="Edit Dr.BP"/> |
| 4. <b>CW</b> | Charles Winchester,DC has no assigned Provider ID      | <input type="button" value="Edit Dr.CW"/> |

Click the drop down arrow to the right of Provider ID. The HCAI list of providers will appear with their Provider ID. Select the correct practitioner from the list and click **Accept**.



**Edit Doctor's settings for MVA forms**

Doctor's name on Official Documents: Benjamin Pierce, DC #6911

Last Name:

First Name:

Profession:

Provider ID:

AIISI Number:

email Address:

Phone Extension:

Please note that th


| Provider ID | First Name | Last Name  | Start Date | End Date | College Reg. No. |
|-------------|------------|------------|------------|----------|------------------|
| 1111        | Elizabeth  | Hurley     | 19/11/2010 |          | 122568           |
| 1230        | Joe        | OCAChiro   | 09/03/2011 |          | DC-872346        |
| 817         | Daniel     | Palmer     | 14/05/2010 |          | 4444             |
| 818         | Benjamin   | Pierce     | 14/05/2010 |          | 2345             |
| 819         | Albert     | Schweizer  | 14/05/2010 |          | J222             |
| 820         | Charles    | Winchester | 14/05/2010 |          | 5896             |



Corrections can be made to this screen but changing the Provider ID and practitioner type will result in rejections.

## Setting Up Clinic Address Information in PMP

Clinic address information is pulled into OCF forms from *Clinic Defaults* in PMP. To make sure your clinic information is correct go into **PMP**, select the **Setup** menu and **Clinic Defaults**. Confirm, correct, or add your clinic information.



**PMPw Clinic Defaults**

Clinic Name: Mississauga Chiropractic Clinic

Phone#: 905-629-8211

Street: 122 Sacroiliac Avenue

City: Mississauga

Province/State: ON

Postal/Zip Code: L4B 1W4

Maximum Ohip:

Maximum XRay:

Default City: Mississauga

## OCF Forms in PMP

PMP makes completion of auto insurance forms easy and uncomplicated. OCF Forms are located in **Patient Information** on the **MVA** tab.

### Patient Information MVA tab

**Accidents**

| Accident ID | Comments | Date       | Insurance Company Name |
|-------------|----------|------------|------------------------|
| 1           |          | 4-Feb-2009 | PMS Vendor Test        |

**Form Data**

New Treatment Plan (OCF18) | New Invoice (OCF21) | New Treatment Confirmation (OCF23) | Create OCF21 from OCF18

New Disability Certificate (OCF3) | New MIT discharge report (OCF24)

| Accident ID | Form ID | Form Type | HCAI status | Document Number | Date        | Draft/Final | Comments | Plan Number | Invoice Number |
|-------------|---------|-----------|-------------|-----------------|-------------|-------------|----------|-------------|----------------|
| 1           | 247     | OCF21     |             |                 | 14-Mar-2011 | Draft       |          |             |                |
| 1           | 217     | OCF21     |             |                 | 23-Feb-2011 | Draft       |          |             |                |
| 1           | 200     | OCF18     | Approved    | 11022300001     | 23-Feb-2011 | Final       |          | 3           |                |
| 1           | 199     | OCF18     | Submitted   | 10121300005     | 1-Dec-2010  | Final       |          | 2           |                |
| 1           | 189     | OCF18     | Submitted   | 10112900013     | 16-Nov-2010 | Final       |          | 1           |                |

**Search for a Patient by**

Next Previous Save Cancel New Patient Last name Number First name Other Continue

Press F2 to add an appointment, or press F10 to process an activity

#### Accidents

The **Accidents** section lists all accidents related to this patient. Buttons in this section are:

- **New Accident** a new accident is created and populated after creating a new form
- **Edit Comments** allows you add a comment to the accident
- **Delete** will delete an accident if there no forms were created using this accident
- the *envelope* icon allows you to use your Dymo LabelMaker to create a label for the insurance company
- **Set MVA A/R Info** shows MVA information listed on this tab prior to the addition of OCF forms.

#### Form Data

All OCF forms required by the HCAI system are created by clicking the appropriate button:

- **New Treatment Plan (OCF 18)**
- **New Invoice (OCF 21)**



- **New Treatment Confirmation (OCF 23)**
- **Create OCF 21 from OCF.** To use this form click onto a finalized OCF18 or 23 form in the list to activate
- **New Disability Certificate (OCF 3) *Note:*** OCF 3 forms are not submitted to HCAI
- **New MIG discharge report (OCF24) *Note:*** OCF 24 forms are not submitted to HCAI

Below the report buttons are your list of forms for this patient. As each report is created it will be listed in this area. Available columns are:

- **Accident ID** Patients can have more than one accident. This field notes which form is being reported on
- **Form ID** Each form created in PMP will have a unique number
- **Form Type** The type of OCF form
- **HCAI status** See below
- **Document Number** A unique reference number assigned to each form by HCAI
- **Date** The last date a form was modified
- **Draft / Final** The completion status of a form
- **Comments** Use this area to make notes that assist you with relevant information
- **Plan Number** Treatment plan number
- **Invoice Number** The invoice number submitted for a treatment plan

The **HCAI Status** column will display the status of the form. Below is a list of the available status's:

- **Ready to Submit** This status is displayed after a form is closed using the 'Save for HCAI' button. These forms will be included in the next batch (group) of forms that are submitted to HCAI
- **Submitted** Displayed when a form was submitted successfully to HCAI
- **Submit Errors** Displayed if a form was rejected by HCAI due to errors
- **Approved** Set by HCAI if responses were retrieved from insurers during communication with HCAI for OCF 18 & 21
- **Responded** Set by HCAI if responses were retrieved from insurers during communication with HCAI for OCF23
- **Partially Approved** Set by HCAI if responses were retrieved from insurers during communication with HCAI when the insurance company has partially approved a form
- **Declined** Set by HCAI if responses were retrieved from insurers during communication with HCAI when the insurance company has not approved the form
- **'blank'** HCAI status field is displayed for forms that are not submitted to HCAI; OCF 3 and 24

- **In transaction** the form is in an error status and has not been sent. Contact support for specific resolution

Buttons listed below forms offer additional functions for the listed forms:

- **Edit Comment** allows you to add comments to a form
- **Edit** allows a *Draft* form to be edited
- **View / Print** will open the viewer and display your form
- **Delete 'Draft'** allows you to delete *Drafts*. **Note:** *Final* forms cannot be edited or deleted
- **View Adjudication** will open a report detailing the insurer response to the specified form.

## Creating OCF Forms for HCAI or DEC Submission

Click onto the **New Accident** button. Click **Yes**, then **OK**.

Click onto one of the Data Form buttons to create the required report. The form will open with the parts in tabs across the top. Click on any tab to go to that specific section.

The screenshot displays the MVA OCF-18 form interface. At the top, there is a tabbed navigation bar with tabs for Part 1/2, Part 3, Part 4, Part 5, Part 6, Part 7, Part 8, Part 9ab, Part 9cde, Part 11, Part 12, Part 12b, Part 13, and Additional Comments. The main form area is divided into sections:

- Form Header:** Contains fields for Claim Number (794943), Policy Number (66656), and Date of Accident (04/11/2010).
- Part 1 - Applicant Information:** Includes fields for Last Name (Linton), Middle Name, First Name (Adrienne), Address (1 Hook Avenue), Date of Birth (06/08/1949), Gender (Female), City (Thornhill), Province (Ontario), Postal Code (L4J 5K9), Telephone Number ((905) 731-0702), and Extension.
- Part 2 - Insurance Company Information:** Includes fields for Insurance Company Name (Aviva Insurance Company of Canada), City of Branch Office (Aviva - Main Branch), Adjuster Last Name, Adjuster First Name, Telephone Number, Extension, Fax Number, and Name of Policy Holder (checked as Same as Applicant).

At the bottom, there is a navigation bar with buttons: Test Form, Test for HCAI, Test for Print, Cancel, Save as 'Draft', Save as 'Finalized' (to paper), and Save for HCAI.

## Additional Buttons

The bottom portion of the form contains the following buttons:

|           |        |               |                              |               |
|-----------|--------|---------------|------------------------------|---------------|
| Test Form | Cancel | Save as Draft | Save as Finalized (to paper) | Save for HCAI |
|-----------|--------|---------------|------------------------------|---------------|

- **Test Form** when pressed will mark a red 'X' on the tabs signifying incomplete parts of the form and highlight specific required fields in yellow.
- **Test for HCAI** or **Print** will modify the test based upon your selection
- **Cancel** closes the form without saving and brings the user back to the Auto screen
- **Save as Draft** will save all information input so far allowing you to edit or complete the form at a later time
- **Save as Finalized (to paper)** saves the form for fax or mail submission. Use this button only when the form will not be submitted electronically for HCAI and for OCF 3 and 24. Finalized forms cannot be edited.
- **Save for HCAI** will add the form to the submission that will be submitted to HCAI the next time a submission is made. To remove a form from the submission choose **Edit** and then **Save as Draft**.

PMP has incorporated HCAI rules into forms. This means that many fields are required and certain pre-requisites or criteria must be met before a form can be submitted to HCAI or finalized for paper submission.

Click **Test Form** to locate incomplete areas of the form that are required. Tabs where validation rules fail will be marked with a red X. Fields will be highlighted in yellow. Move your mouse over yellow fields to produce a hint. Once a yellow field has been completed the colour will return to normal upon choosing **Test Form** again.

If you are unable to complete the form click **Save as Draft**. The form will be saved as a **Draft** on the main Auto screen. Click **Edit Comments**. Type a comment relating to the status or missing information pertaining to this form. Click **OK**. The comment will now be added to the form. To continue to input information into a draft form click the form in the list followed by **Edit**.

When the form is complete click either **Save as Finalized** if the form is *not being submitted electronically to HCAI* or **Save for HCAI** if the form will be submitted electronically through the PMP HCAI module.

The form will then be saved with a status of *Ready to Submit*. Once the PMP HCAI module has been accessed the form will be sent with the submission to HCAI.

To remove a form from the submission, click the form and **Edit**. Once the form is open choose **Save as Draft**. This returns to form to 'draft' mode and will remove it from the submission.



OCF 3 and 24 forms are not sent through HCAI, finalize these forms for fax or mail to auto insurers. Keep in mind, *Finalized* forms cannot be edited or deleted; we recommend printing draft forms and double checking for accuracy before finalizing.

## OCF 23 New Treatment Confirmation

The health practitioner who initiates pre-approved treatment for an injury defined in the Minor Injury Guideline (MIG) (for accidents on or after September 1, 2010) and the Pre-approved Framework (PAF) (for accidents before September 1, 2010) must fully complete a Treatment Confirmation Form, OCF-23, in order to establish the Initiating Health Practitioner's right to reimbursement for the delivery of MIG/FAF treatment.

Click on to the **New Accident** button. Click **Yes**, then **OK**.

Click the **New Treatment Confirmation (OCF23)** button. The form will open with the parts in the tabs across the top. Click on any tab to go to that specific tab.

The screenshot shows the 'Patient Information' window for '51 - Amber Linton'. The 'Accidents' section has a table with one entry: Accident ID 110, Comments, Date, and Insurance Company Name. Below this is a 'New Accident' button. The 'Form Data' section has tabs for 'New Treatment Plan (OCF18)', 'New Invoice (OCF21)', 'New Treatment Confirmation (OCF23)' (which is highlighted), and 'Create OCF21 from OCF'. Below these tabs is a table with columns: Accident ID, Form ID, Form Type, HCAI status, Document Number, Date, Draft/Final, Comments, Plan Number, and Invoice Number. At the bottom, there are buttons for 'Send this patient to CW', 'Next', 'Previous', 'Save', 'Cancel', 'New Patient', and a 'Search for a Patient by' section with fields for Last name, Number, First name, and Other, followed by a 'Continue' button.

### Part 1 Applicant Information

The screenshot shows the 'Part 1 - Applicant Information' form. It includes a 'Form Header' section with fields for 'Claim Number' (794943), 'Policy Number' (66656), and 'Date of Accident' (04/11/2010). Below this is the 'Part 1 - Applicant Information' section with fields for 'Last Name' (Linton), 'Middle Name', 'First Name' (Adrienne), 'Address' (1 Hook Avenue), 'City' (Thornhill), 'Province' (Ontario), 'Postal Code' (L4J 5K9), 'Date of Birth' (06/08/1949), 'Gender' (Female), 'Telephone Number' ((905) 731-0702), and 'Extension'.

These fields will be populated with information pulled from the patient file. Some fields can be edited but changes to these fields will be reflected in the field where the information was pulled from. For

example if you change the telephone number in Part 1 the change will reflect on the Patient Information Info 1 tab. Fields where information can be updated are indicated by an underline. Positioning your mouse over an updatable field will produce a hint signifying where the change will be reflected. See illustration below.

**Telephone Number**

90573101

**Patient Table**  
This data field is connected to the live Patient database.  
A change made here is the same as changing it in Patient Info

## Part 2 Insurance Company Information

**Part 2 - Insurance Company Information**

Insurance Company Name  Clear City of Branch Office  Clear

Adjuster Last Name  Adjuster First Name

Telephone Number  Extension

Name of Policy Holder  
☐ Same as Applicant  
 Policy Holder Last Name  Policy Holder First Name

Fax Number

Some fields contain a drop down box where information is selected. Choose Insurance Company and Branch from the lists.

MVA OCF-18

Part 1/2 | Part 3 | Part 5 | Part 6 | Part 7 | Part 8 | Part 9 | Part 10ab | Part 10cde | Part 11 | Part 12 | Part 12b | Additional Cr

**Form Header**  
 Claim Number 434454 Policy Number 343344 Date of Accident 08/01/2008

**Part 1 - Applicant Information**  
 Last Name Smith Middle Name First Name Lillian  
 Address 1545 Explorer Drive Date of Birth 12/05/1981 Gender Female  
 City Toronto Province Ontario Postal Code L4Y 2E4 Telephone Number (416) 555-1212

**Part 2 - Insurance Company Information**  
 Insurance Company Name  Clear City of Branch Office  Clear  
 Adjuster First Name   
 Policy Holder First Name   
 Draft Save as 'Finalized' (unalterable)

Insurance Company Name dropdown menu:  
 ING Insurance Company of Canada  
 ING Novex Insurance Company of Canada  
 Jevco Insurance Company  
 Kent & Essex Mutual Insurance Company  
 L & A Mutual Insurance Company  
 Lambton Mutual Insurance Company  
 Lanark Mutual Insurance  
 Lombard General Insurance Company of Canada



If you are submitting through the PMP HCAI interface the insurer list will be updated every time you connect to HCAI.

## Part 3 Other Insurance Information

**Part 3 - Other Insurance**

Is there other insurance coverage for any goods and services listed in this Treatment Plan? ☒ No ☐ Yes

Is there Ministry of Health (MOH) coverage for any goods and services in this Treatment Plan? ☒ No ☐ Yes ☐ Not Applicable

**Other Insurer 1**  
 Insurer Name  Insurance Plan or Policy Number   
 Name of Plan Member  Insurer's Identifier

**Other Insurer 2**  
 Insurer Name  Insurance Plan or Policy Number   
 Name of Plan Member  Insurer's Identifier

Type in any other insurer; i.e.. Ministry of Health, Extended Health Care Plan, or any others.

Part 4      Signature of Health Practitioner

Part 4

Part 4 - Signature of Health Practitioner

Doctor Clear

DD

Last Name

Palmer

First Name

Daniel

Provider ID

4444

Facility Name

Ontario Health and Rehabilitation Ctr.

AISI Facility Number

Address

123 Victoria Street

College Registration Number

4444

City

Toronto

Province

Ontario

Postal Code

M1A 2B3

Profession

Chiropractor

Telephone Number

416-860-7199

Extension

Fax Number

Email Address

☒ Signature on File

Signature Date clear

02/06/2010

☐ I am not the first Initiating Health Practitioner

Complete the Signature of Health Practitioner information. Only practitioners listed below are permitted to completion this section:

- Chiropractor
  - Family / General Practitioner
  - Occupational Therapist
  - Optometrist
  - Physiotherapist
  - Psychologist
  - Pathologist
- Dentist
  - Nurse Practitioner
  - Ophthalmologist
  - Other Medical / Surgical Practitioner
  - Psychiatrist
  - Speech-Language

The signature on file and signature date boxes are required fields when sending forms electronically. Signatures are not transmitted to the insurer; however, hard copies of the form must be printed and signed and kept on file. To obtain signatures, the entire OCF should be completed. It is not advisable for health professionals or claimants to sign incomplete forms. Print the completed draft form and have the Health Practitioner sign it.

Part 5      Injury and Sequelae Information

A large selection of commonly used codes have been incorporated into PMP however due to the size of the full code list, not all are included. Item number 4 below details how to use a code not found in the PMP list.

Part 6

Part 6 - Injury and Sequela Information

Injury 1 Clear

Injury Description (Primary Complaint)

Subluxation complex (vertebral)

ICD-10 Injury Code

M991

Injury 2 Clear

Injury Description

ICD-10 Injury Code

Injury 3 Clear

Injury Description

ICD-10 Injury Code

To access codes select the browse button to the right of ICD-10 Injury Code.



There are many ways to select codes from the list:

The purpose of this screen is to build an ICD-10 code, and leave happy. You build the code from left to right with the grid showing you the way.

a) type into the Code edit box.  
b) arrow or click through the grid.  
c) type keyword(s) into the Description box.

When you have a code you like, press enter or double click, or click OK.

1. type the known code into the code box
2. click onto the written description to expand that item, continue to click on descriptions until the desired selection is reached
3. type keywords or part of keywords into the blank field below **Description**. Part of words will suffice, such as sub for subluxation. You can choose two keywords, separated by a comma. Example: **kn,sp** will locate eight items related to knee sprain
4. on the main injury screen click into the **Injury Description** field and type the description then click into the ICD-10 Code field and type the code. This manner of selection is used for codes not found in the current list.

## Part 6 Prior and Concurrent Conditions

Click the radio buttons to answer each question. Your answer may open a field where detailed information is typed into. **Explain** boxes are required fields and you will not be able to complete the form without inputting information.

## Part 7 Barriers to Recovery

Part 7/8

**Part 7 - Barriers to recovery**

Have you identified any barriers to recovery? ☒ No ☐ Yes

If you choose **Yes** you will be prompted to complete the **Explain** box. This is a required field and you will not be able to complete the form without inputting information.

## Part 8 Signature of Applicant

**Part 8 - Signature of Applicant**

Has the insurer waived the requirement of the applicant's signature? ☒ No ☐ Yes

Name of Applicant or Substitute Decision Maker

|           |            |   |
|-----------|------------|---|
| Last Name | First Name | <input checked="" type="checkbox"/> Signature on File |
| 564554354 | 48545454   | Signature Date  |
|           |            | 01/06/2010 <input type="button" value="clear"/>       |

The signature on file and signature date boxes are required fields when sending forms electronically. Signatures are not transmitted to the insurer; however, hard copies of the form must be printed and signed and kept on file. To obtain signatures, the entire OCF should be completed. It is not advisable for health professionals or claimants to sign incomplete forms. Print the completed draft form and have the claimant sign it.

## Part 9 Guideline Services

Part 9

**Part 9 Guideline Services**

| Category  | Description                                | Maximum Fee   | Estimated Fee |               |
|---|--|---------------|---------------|---------------|
| Identify which Guideline is applicable                    | MIG  | 0.00          | 0.00          |               |
| *Supplementary Goods and Services                         |  | 0.00          | 0.00          |               |
| <b>*Other Pre-approved Services (including Radiology)</b> |  |               |               |               |
| Code  | Description                                | Views         | Maximum Fee   | Estimated Fee |
| 3SC10   | X-Ray of the Cervical Spine                | Select A View | 0.00          | 0.00          |
| 3SC10   | X-Ray of the Thoracic Spine                | Select A View | 0.00          | 0.00          |
| 3SC10   | X-Ray of the Lumbar Spinal Vertebrae       | Select A View | 0.00          | 0.00          |
| 3SC10   | X-Ray of the Lumbrosacral Spinal Vertebrae | Select A View | 0.00          | 0.00          |
| <b>Part 9 Sub-Total</b>                                   |  |               | 0.00          | 0.00          |

Type applicable fees and any additional information.



## Part 10 Other Health Providers

| Part 10 - Other Health Providers        |           |           |             |                     |             |             |  |
|---|-----------|-----------|-------------|---------------------|-------------|-------------|--|
| Doctor                                  | FirstName | Last Name | Provider ID | College Reg. Number | AISI Number | Hourly Rate |  |
| Clear<br>A DD DC Daniel Palmer 817 4444 |           |           |             |                     |             |             |  |
| Clear<br>B                              |           |           |             |                     |             |             |  |
| Clear<br>C                              |           |           |             |                     |             |             |  |
| Clear<br>D                              |           |           |             |                     |             |             |  |

Part 10 will populate from information input into a previous OCF form or choose practitioners from the PMP list below **Doctor**.



If the provider is not included on the drop down list under **Doctor** type the practitioner details into all remaining fields, leaving the first field blank.

## Additional Comments

| Additional Comments |
|---------------------|
| <div></div>         |

The Additional Comments tab is for attachment information if applicable or any other information to support the treatment plan. Up to 20,000 characters can be used in this field.

### Additional Buttons

The bottom portion of the form contains the following buttons:

|           |  |        |                 |                                |               |
|-----------|--|--------|-----------------|--------------------------------|---------------|
| Test Form | <input checked="" type="radio"/> Test for HCAI<br><input type="radio"/> Test for Print | Cancel | Save as 'Draft' | Save as 'Finalized' (to paper) | Save for HCAI |
|-----------|--|--------|-----------------|--------------------------------|---------------|

- **Test Form** when pressed will marks a red 'X' on the tabs signifying incomplete parts of the form and highlight specific required fields in yellow
- **Test for HCAI** or **Print** will modify the test based upon your selection
- **Cancel** closes the form without saving and brings the user back to the Auto screen

- **Save as Draft** will save all information input so far allowing you to edit or complete the form at a later time
- **Save as Finalized (to paper)** saves the form for fax or mail submission. Use this button only when the form will not be submitted electronically for HCAI and for OCF 3 and 24. Finalized forms cannot be edited.
- **Save for HCAI** will add the form to the batch (group) of forms that will be submitted to HCAI the next time a submission is made. To remove a form from the submission choose **Edit** and then **Save as Draft**.

Click **Test Form** to locate incomplete areas of the form that are required. Tabs where validation rules fail will be marked with a red X. Fields will be highlighted in yellow. Move your mouse over yellow fields to produce a hint. Once a yellow field has been completed the colour will return to normal upon choosing **Test Form** again.

If you are unable to complete the form click **Save as Draft**. The form will be saved as a **Draft** on the main Auto screen. Click **Edit Comments**. Type a comment relating to the status or missing information pertaining to this form. Click **OK**. The comment will now be added to the form. To continue to input information into a form click the draft form in the list followed by **Edit**.

When the form is complete click either **Save as Finalized** if the form is not being submitted electronically to HCAI or **Save for HCAI** if the form will be submitted electronically through the PMP HCAI module.

OCF 3 and 24 forms are not sent through HCAI, finalize these forms for fax or mail to auto insurers. Keep in mind, *Finalized* forms cannot be edited or deleted; we recommend printing draft forms and double checking for accuracy before finalizing.

## OCF 18 Treatment Plan

The OCF 18 Treatment Plan is completed by health care providers to provide a guideline to insurers regarding:

- cause and nature of injuries resulting from a motor vehicle accident
- identify limitations
- identify treatment plan and goals
- prior and concurrent conditions
- proposed treatment and estimated costs
- increase accountability of all parties involved.

Click onto the **New Accident** button. Click **Yes**, then **OK**.

Click the **New Treatment Plan (OCF18)** button. The form will open with the all the parts in tabs across the top. Click on any tab to go to that specific tab.

The screenshot shows the MVA OCF-18 form with the following data:

| Form Header            |                        |                                |
|------------------------|------------------------|--------------------------------|
| Claim Number<br>794943 | Policy Number<br>66656 | Date of Accident<br>04/11/2010 |

| Part 1 - Applicant Information |                     |                        |                                    |                  |  |
|--------------------------------|---------------------|------------------------|------------------------------------|------------------|--|
| Last Name<br>Linton            | Middle Name         | First Name<br>Adrienne |                                    |                  |  |
| Address<br>1 Hook Avenue       |                     |                        | Date of Birth<br>06/08/1949        | Gender<br>Female |  |
| City<br>Thornhill              | Province<br>Ontario | Postal Code<br>L4J 5K9 | Telephone Number<br>(905) 731-0702 | Extension        |  |

| Part 2 - Insurance Company Information                      |  |  |
|---|--|--|
| Insurance Company Name<br>Aviva Insurance Company of Canada | City of Branch Office<br>Aviva - Main Branch |  |
| Adjuster Last Name  | Adjuster First Name                          |  |
| Telephone Number  | Extension                                    | Name of Policy Holder<br><input checked="" type="checkbox"/> Same as Applicant |
| Fax Number  |  |  |

At the bottom, there are buttons: Test Form, Test for HCAI, Test for Print, Cancel, Save as 'Draft', Save as 'Finalized' (to paper), and Save for HCAI.

### Part 1 Applicant Information

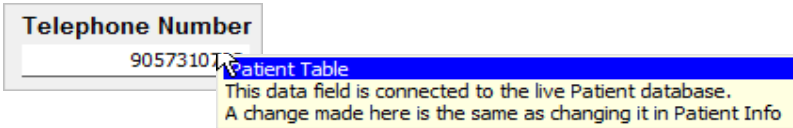
This is a zoomed-in view of the form sections shown in the previous screenshot:

| Form Header            |                        |                                |
|------------------------|------------------------|--------------------------------|
| Claim Number<br>794943 | Policy Number<br>66656 | Date of Accident<br>04/11/2010 |

| Part 1 - Applicant Information |                     |                        |                                    |                  |  |
|--------------------------------|---------------------|------------------------|------------------------------------|------------------|--|
| Last Name<br>Linton            | Middle Name         | First Name<br>Adrienne |                                    |                  |  |
| Address<br>1 Hook Avenue       |                     |                        | Date of Birth<br>06/08/1949        | Gender<br>Female |  |
| City<br>Thornhill              | Province<br>Ontario | Postal Code<br>L4J 5K9 | Telephone Number<br>(905) 731-0702 | Extension        |  |

These fields will be populated with information pulled from the patient file. Some fields can be edited but changes to these fields will be reflected in the field where the information was pulled from. For example if you change the telephone number in Part 1 the change will reflect on the Patient Information Info 1 tab. Fields where information can be updated are indicated by an underline. Positioning your mouse over an updatable field will produce a hint signifying where the change will be reflected. See illustration below.



## Part 2 Insurance Company Information

| Part 2 - Insurance Company Information      |                                |  |   |
|---|--------------------------------|--|---|
| Insurance Company Name <input type="text"/> |                                | City of Branch Office <input type="text"/>   |   |
| Adjuster Last Name <input type="text"/>     |                                | Adjuster First Name <input type="text"/>     |   |
| Telephone Number <input type="text"/>       | Extension <input type="text"/> | Name of Policy Holder                        |   |
| Fax Number <input type="text"/>             |                                | <input type="checkbox"/> Same as Applicant   |   |
|   |                                | Policy Holder Last Name <input type="text"/> | Policy Holder First Name <input type="text"/> |

Some fields contain a drop down box where information is selected. Choose Insurance Company and Branch from the lists.



If you are submitting forms through the PMP HCAI interface this



If you are submitting OCF forms through the PMP HCAI interface the insurer list will be updated every time you connect to HCAI.

## Part 3 Other Insurance Information

**Part 3**

**Part 3 - Other Insurance**

Is there other insurance coverage for any goods and services listed in this Treatment Plan? ☒ No ☐ Yes

Is there Ministry of Health (MOH) coverage for any goods and services in this Treatment Plan? ☒ No ☐ Yes ☐ Not Applicable

**Other Insurer 1**

|                            |  |
|----------------------------|--|
| <b>Insurer Name</b>        | <b>Insurance Plan or Policy Number</b> |
|                            |  |
| <b>Name of Plan Member</b> | <b>Insurer's Identifier</b>            |
|                            |  |

**Other Insurer 2**

|                            |  |
|----------------------------|--|
| <b>Insurer Name</b>        | <b>Insurance Plan or Policy Number</b> |
|                            |  |
| <b>Name of Plan Member</b> | <b>Insurer's Identifier</b>            |
|                            |  |

Type in any other insurer; i.e.. Ministry of Health, Extended Health Care Plan, or any others.

## Part 4 Signature of Health Practitioner

**Part 4**

**Part 4 - Signature of Health Practitioner**

|  |                            |                               |   |
|--|----------------------------|-------------------------------|---|
| <b>Doctor</b><br>DD  | <b>Last Name</b><br>Palmer | <b>First Name</b><br>Daniel   | <b>Provider ID</b><br>817                             |
| <b>Facility Name</b><br>Ontario Health and Rehabilitation Ctr. |                            |                               | <b>AIISI Facility Number</b>                          |
| <b>Address</b><br>123 Victoria Street                          |                            |                               | <b>College Registration Number</b><br>1234            |
| <b>City</b><br>Toronto   | <b>Province</b><br>Ontario | <b>Postal Code</b><br>M1A 2B3 | <b>Profession</b><br>Chiropractor                     |
| <b>Telephone Number</b><br>416-860-7199                        | <b>Extension</b>           | <b>Fax Number</b>             | <input checked="" type="checkbox"/> Signature on File |
| <b>Email Address</b>   |                            |                               | <b>Signature Date</b><br>01/12/2010                   |

Is this impairment predominantly a minor injury as referred to in the Minor Injury Guideline? ☒ No ☐ Yes

Please explain and provide compelling evidence why the applicant does not come within the Minor Injury Guideline due to a pre-existing medical condition that will prevent the applicant from achieving maximal recovery from the minor injury if the applicant is subject to the \$3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.

Complete the Signature of Health Practitioner information. Only practitioners listed below are permitted to completion this section:

- Chiropractor
- Dentist
- Family / General Practitioner
- Nurse Practitioner
- Occupational Therapist
- Ophthalmologist
- Optometrist
- Other Medical / Surgical Practitioner
- Physiotherapist
- Psychiatrist
- Psychologist
- Speech-Language
- Pathologist

The signature on file and signature date boxes are required fields when sending forms electronically. Signatures are not transmitted to the insurer; however, hard copies of the form must be printed and signed and kept on file. To obtain signatures, the entire OCF should be completed. It is not advisable for health professionals or claimants to sign incomplete forms.

Print the completed draft form and have the Health Practitioner sign it.

## Part 5 Signature of Regulated Health Practitioner or Social Worker

Part 5 - Signature of Regulated Health Professional or Social Worker

Is this the same person as in Part 4 ? ☒ No ☐ Yes

**Doctor**  **Last Name**  **First Name**  **Provider ID**

**Facility Name**  **AISI Facility Number**

**Address**  **College Registration Number**

**City**  **Province**  **Postal Code**  **Profession**

**Telephone Number**  **Extension**  **Fax Number**

**Email Address**  ☒ Signature on File **Signature Date**

If the health practitioner selected in Part 4 is willing to supervise the plan, select “Yes” in response to this question. If the health practitioner selected in Part 5 is not the same as Part 4, select “No” in response to this question and complete Part 5.

Select the practitioner from the list under the field **Doctor**. Type required information into empty fields. **Note:** If the provider is not included on the drop down list under Doctor, type the practitioner details into all remaining fields, leaving the Code field blank.

The signature on file and signature date boxes are required fields when sending forms electronically. Signatures are not transmitted to the insurer; however, hard copies of the form must be printed and signed and kept on file. To obtain signatures, the entire OCF should be completed. It is not advisable for health professionals or claimants to sign incomplete forms.

Print the completed draft form and have the Regulated Health Practitioner sign it.

## Part 6 Injury and Sequelae Information

A large selection of commonly used codes have been incorporated into PMP however due to the size of the full code list, not all are included. Item number 4 below details how to use a code not found in the PMP list.

Part 6 - Injury and Sequela Information

**Injury 1**

**Injury Description (Primary Complaint)**  **ICD-10 Injury Code**

**Injury 2**

**Injury Description**  **ICD-10 Injury Code**

**Injury 3**

**Injury Description**  **ICD-10 Injury Code**

To access codes select the browse button to the right of **ICD-10 Injury Code**.



There are many ways to select codes from the list:

1. type the known code into the code box
2. click onto the written description to expand that item, continue to click on descriptions until the desired selection is reached
3. type keywords or part of keywords into the blank field below **Description**. Part of words will suffice, such as sub for subluxation. You can choose two keywords, separated by a comma. Example: **kn,sp** will locate eight items related to knee sprain
4. on the main injury screen click into the **Injury Description** field and type the description then click into the ICD-10 Code field and type the code. This manner of selection is used for codes not found in the current list.

**ICD-10 Code Picker**

| Code | Description                       |
|------|-----------------------------------|
| F    | Mental & Behavioural              |
| G    | Diseases - Nervous System         |
| K    | Temporomandibular Joint Disorders |
| M    | Diseases - Musculoskeletal System |
| R    | Abnormal Signs & Symptoms         |
| S    | Injuries                          |

The purpose of this screen is to build an ICD-10 code, and leave happy. You build the code from left to right with the grid showing you the way.

a) type into the Code edit box.  
b) arrow or click through the grid.  
c) type keyword(s) into the Description box.

When you have a code you like, press enter or double click, or click OK.

Cancel OK

**Part 6 - Injury and Sequela Information**

**Injury 1** Clear

Injury Description (Primary Complaint) ICD-10 Injury Code

**Injury 2** Clear

Injury Description ICD-10 Injury Code

**Injury 3** Clear

Injury Description ICD-10 Injury Code

## Part 7 Prior and Concurrent Conditions

Click the radio buttons in answer to each question. Your answer may open a field where detailed information is typed into. **Explain** boxes are required fields and you will not be able to complete the form without inputting information.

**Part 7 - Prior and Concurrent Conditions**

Prior to the accident, did the applicant have any disease, condition or injury that could affect his/her response to treatment for the injuries identified. ☒ No ☐ Unknown ☐ Yes

Since the accident, has the applicant developed any other disease, condition or injury not related to the accident that could affect response to treatment. ☒ No ☐ Unknown ☐ Yes

## Part 8 Activity Limitations

As with part 7, answer each question using the radio buttons. Your responses may open a field where detailed information is typed into. **Explain** boxes are required fields and you will not be able to complete the form without inputting information.

| Part 8   |                                    |                                     |                               |                           |
|--|------------------------------------|-------------------------------------|-------------------------------|---------------------------|
| <b>Part 8 - Activity Limitations</b>   |                                    |                                     |                               |                           |
| Does the applicant's impairment(s) from the injuries sustained in the automobile accident affect his/her ability to carry out:                           |                                    |                                     |                               |                           |
| His/her tasks of employment  | <input type="radio"/> Not employed | <input checked="" type="radio"/> No | <input type="radio"/> Unknown | <input type="radio"/> Yes |
| His/her activities of normal life  |                                    | <input checked="" type="radio"/> No | <input type="radio"/> Unknown | <input type="radio"/> Yes |
| If the applicant is unable to carry out pre-accident employment activity, is the employer able to provide suitable modified employment to the applicant. | <input type="radio"/> Not employed | <input checked="" type="radio"/> No | <input type="radio"/> Unknown | <input type="radio"/> Yes |
| <b>Explain</b>   |                                    |                                     |                               |                           |
| <div> <div>dklasjldksjdsad</div> <div></div> </div>  |                                    |                                     |                               |                           |

## Part 9 Treatment Plan Goals

Part 9 is spread over two tabs. Handle these tabs in the same manner as previous tabs.

| Part 9ab  |   |
|---|---|
| <b>Part 9 - Treatment Plan Goals</b>  |   |
| <b>Goals</b>  |   |
| Identify the Goal(s) that this Treatment Plan seeks to achieve:   | <input checked="" type="checkbox"/> Pain reduction<br><input type="checkbox"/> Increase in strength<br><input type="checkbox"/> Increase in range of motion<br><input type="checkbox"/> other(s) / Not Applicable   |
| Select the functional goal(s) that this Treatment Plan seeks to achieve:                                      | <a href="#">Return to:</a><br><input checked="" type="checkbox"/> Normal living activities<br><input type="checkbox"/> Modified work activities<br><input checked="" type="checkbox"/> Pre-accident work activities<br><input type="checkbox"/> other(s) / Not Applicable |
| <b>Evaluation</b>   |   |
| How will progress on the goal(s) above be evaluated?  |   |
| <div> <div></div> <div></div> </div>  |   |
| If this is a subsequent treatment plan, what was the applicant's improvement at the end of the previous plan. |   |
| <div> <div></div> <div></div> </div>  |   |

| Part 9cde                                     |  |
|---|--|
| <b>Part 9 - Treatment Plan Goals</b>          |  |
| <b>Barriers to recovery</b>                   |  |
| Have you identified any barriers to recovery? | <input checked="" type="radio"/> No<br><input type="radio"/> Yes |
| <b>Concurrent Treatment</b>                   |  |
| Are you aware of any concurrent treatment?    | <input checked="" type="radio"/> No<br><input type="radio"/> Yes |



## Part 11 Health Providers

| Part 11 - Other Health Providers |           |           |                     |             |             |  |  |
|----------------------------------|-----------|-----------|---------------------|-------------|-------------|--|--|
| Doctor                           | FirstName | Last Name | Registration Number | AISI Number | Hourly Rate |  |  |
| <b>A</b> 1                       | DC        | Daniel    | Palmer              | 1234        |             |  |  |
| <b>B</b> AT                      | MT        | Susan     | Jackson             | G123        |             |  |  |
| <b>C</b>                         |           |           |                     |             |             |  |  |
| <b>D</b>                         |           |           |                     |             |             |  |  |
| <b>E</b>                         |           |           |                     |             |             |  |  |
| <b>F</b>                         |           |           |                     |             |             |  |  |

Select all treating practitioners from the PMP list under **Doctor**. Type required information into empty fields.

**Note:** If the provider is not included on the drop down list under **Doctor** type the practitioner details into all remaining fields, leaving the first field blank.

## Part 12 Proposed Goods and Services

| Part 12 Proposed Goods and Services |      |             |           |                    |                |         |      |             |            |
|-------------------------------------|------|-------------|-----------|--------------------|----------------|---------|------|-------------|------------|
| G/S Ref                             | Code | Description | Attribute | Provider Reference | Estimate / Day |         |      | Total Count | Total Cost |
|                                     |      |             |           |                    | Quantity       | Measure | Cost |             |            |
|                                     |      |             |           |                    |                |         |      |             |            |

Goods and Services on Part 12 is where CCI and GAP codes are chosen. Click **Add**.

There are many ways to select codes from the list:

1. type the known code into the code box
2. click onto the written description to expand that item, continue to click on descriptions until the desired selection is reached
3. type keywords or part of keywords into the blank field below **Description**. Part of words will suffice, such as man for manipulation . You can choose two keywords, separated by a comma. Example: **man,sp** will locate items related to manipulation spine.

| Code  | Description                               | Measure | Unit Cost | P<br>S<br>T | G<br>S<br>T |
|-------|---|---------|-----------|-------------|-------------|
| 1SC05 | Manipulation, spinal vertebrae            |         |           | N           | N           |
| 2EL70 | Inspection, temporomandibular joint [TMJ] |         |           | N           | N           |
| AXXCT | Claimant Transportation                   |         |           | N           | N           |

The purpose of this screen is to build a CCI code, and leave happy.  
You build the code from left to right with the grid showing you the way.

a) type into the Code edit box.  
b) arrow or click through the grid.  
c) type keyword(s) into the Description box.

When you have a code you like, press enter or double click, or click OK.

OK Cancel

After selecting codes input information for each item into relevant fields in the lower screen.

| Code  |  | Description                  | Attribute | Provider Ref     |
|-------|--|------------------------------|-----------|------------------|
| 12X12 |  | Therapy, multiple body sites | 1         | A> Daniel Palmer |

| Estimated Quantity | Measure | Unit Cost* | Cost   | Taxes      | Total Total Count | Total Cost |
|--------------------|---------|------------|--------|------------|-------------------|------------|
| 3                  | 4       | 5          | 6 0.00 | 7 HST 0.00 | 8 1               | 0.00       |

*Edit Goods and Services line item:*

- ① **Attributes** can be added to further specify healthcare services. See *Appendix B* page E-9 for details (see back page)
- ② **Provider Ref** pulls the treating doctor from the populated list on part 11 of your form.
- ③ **Quantity** indicates the amount of a specific item such as km or pages. It is not used for amount of treatments required during the plan, use Total Count for visits
- ④ **Measure** relates to what quantity is measured in such as procedure, KM, time, etc.
- ⑤ **Unit Cost** is used to calculate the Cost of an item by multiplying Quantity times the Unit Cost, i.e. 50 km x .40 cents. The Cost field automatically calculated the amount and input the \$20.00.

| Estimated Quantity | Measure | Unit Cost* | Cost  | Taxes    |
|--------------------|---------|------------|-------|----------|
| 50                 | Km      | 0.4        | 20.00 | HST 0.00 |

- ⑥ **Cost** of an item can be manually typed in or will be populated automatically when amounts are input in Quantity, Measure, and Unit Cost
- ⑦ **HST** automatically calculates when checked

- ⑧ **Total Count** is where the total amount of sessions or items is specified.



Hints will appear when you position your mouse over an item in question. If a field is yellow and has not passed the validation rule the hint box will show a red line with the message **Error:** and a reason for the error. A blue **Hint:** line will detail how to use the field.

## Grouping

Goods and services can be grouped to allow for multi-selection of dates, practitioners, total count, and deletion of items.

The screenshot shows a window titled 'Part 12 Proposed Goods and Services'. It contains a table with the following data:

| G/S Ref | Code  | Description                    | Attribute | Provider Reference | Quantity | Measure   | Estimate / Day Cost | Total Count | Total Cost |
|---------|-------|--------------------------------|-----------|--------------------|----------|-----------|---------------------|-------------|------------|
| 1       | 1SC05 | Manipulation, spinal vertebrae |           | A                  | 1        | Procedure | 0.00                | 1           | 0.00       |
| 2       | 1ZX12 | Therapy, multiple body sites   |           | C                  | 1        | Procedure | 80.00               | 1           | 80.00      |
| 3       | 2SC08 | Test, spinal vertebrae         |           | A                  | 1        | Procedure | 0.00                | 1           | 0.00       |
| 4       | 3SC10 | Xray, spinal vertebrae         |           | A                  | 1        | Procedure | 0.00                | 1           | 0.00       |

Below the table is a section titled 'Editing Selected Goods and Services line items' with a 'Cancel' button. It has two main areas:

- Set a value in all selected records:**
  - Total Count:** A text input field with an 'Apply to Selected' button.
  - Provider Reference:** A dropdown menu showing 'A> Daniel Palmer' with an 'Apply to Selected' button.
- Do this to all selected records:**
  - Delete Selected records
  - Create Session with selected records
  - Remove from Session

**Shift-click.** Click onto a selected CCI code, hold down the **shift** key, and then click onto the last item in the group. All items in between will be highlighted for grouping.

**Ctrl-click.** While holding down the **ctrl** key, click on each item to be selected for grouping.

Release the **ctrl** key when all items have been selected.

Once item have been selected choose a function from the bottom portion of the screen apply.

## Sessions

PMP offers the ability to create sessions. Session fee codes are billing codes that providers may wish to use for a group of physical rehabilitation services. To create a session, before or after goods and services are chosen, click the **Create Session** button. An item line will appear at the top with the code SZZPR, this is the session code. All items with a beginning code of 1, 2, or 6 will be automatically added to the session.

Part 12 Proposed Goods and Services

| G/S Ref | Code  | Description                    | Attribute | Provider Reference | Estimate / Day |           |       | Total Count | Total Cost |
|---------|-------|--------------------------------|-----------|--------------------|----------------|-----------|-------|-------------|------------|
|         |       |                                |           |                    | Quantity       | Measure   | Cost  |             |            |
| 1       | 1SC05 | Manipulation, spinal vertebrae |           | A                  | 5              | Procedure | 20.00 |             |            |
| 2       | 1ZX12 | Therapy, multiple body sites   |           | B                  | 5              | Procedure | 80.00 |             |            |
| 3       | 1ZZ03 | Immobilization, total body     |           | A                  | 1              | Procedure | 10.00 |             |            |
| 4       | 2SC08 | Test, spinal vertebrae         |           | A                  | 1              | Procedure | 5.00  |             |            |
| 5       | 3SC10 | Xray, spinal vertebrae         | B         | A                  | 1              | Procedure | 50.00 | 1           | 50.00      |

Part 12 Proposed Goods and Services

| G/S Ref | Code  | Description                    | Attribute | Provider Reference | Estimate / Day |           |        | Total Count | Total Cost |
|---------|-------|--------------------------------|-----------|--------------------|----------------|-----------|--------|-------------|------------|
|         |       |                                |           |                    | Quantity       | Measure   | Cost   |             |            |
| 1       | SZZPR | Physical Rehabilitation        |           |                    |                | Session   | 115.00 | 1           | 115.00     |
|         | 1SC05 | Manipulation, spinal vertebrae |           | A                  | 5              | Procedure | 20.00  |             |            |
|         | 1ZX12 | Therapy, multiple body sites   |           | B                  | 5              | Procedure | 80.00  |             |            |
|         | 1ZZ03 | Immobilization, total body     |           | A                  | 1              | Procedure | 10.00  |             |            |
|         | 2SC08 | Test, spinal vertebrae         |           | A                  | 1              | Procedure | 5.00   |             |            |
| 2       | 3SC10 | Xray, spinal vertebrae         | B         | A                  | 1              | Procedure | 50.00  | 1           | 50.00      |

Delete

Save

Create Session

Remove from Session

Edit Goods and Services line item

Code

SZZPR

Description

Physical Rehabilitation

Total

Total Count

1

Total Cost

115.00

Items within the session do not have a number listed below the **G/S Ref** column. Goods and services can be added or removed from a session by clicking the **Add to Session** or **Remove from Session** buttons. Type the amount of sessions to be billed into the **Total Count** field in the lower right.

Save and Load Goods

The **Save Goods** and **Load Goods** buttons allow users to save a group of Goods and Services for use on other patient forms. Goods can be saved with session, practitioners and costs. This makes future forms easier when treatment plans for different patients have similar goods.

Part 12

Part 12 Proposed Goods and Services

| G/S Ref | Code  | Description                         | Attribute | Provider Reference | Estimate / Day |           |       | Total Count | Total Cost |
|---------|-------|-------------------------------------|-----------|--------------------|----------------|-----------|-------|-------------|------------|
|         |       |                                     |           |                    | Quantity       | Measure   | Cost  |             |            |
| 1       | SZZPR | Physical Rehabilitation             |           |                    |                | Session   | 30.00 | 1           | 30.00      |
|         | 1SC05 | Manipulation, spinal vertebrae      |           | A                  | 1              | Procedure | 25.00 |             |            |
|         | 2SC08 | Test, spinal vertebrae              |           | A                  | 1              | Procedure | 5.00  |             |            |
| 2       | 1ZX12 | Therapy, multiple body sites        |           | B                  | 1              | Procedure | 80.00 | 1           | 80.00      |
| 3       | 2ZZ02 | Assessment (examination), total bod |           | A                  | 1              | Procedure | 90.00 | 1           | 90.00      |
| 4       | 3SC10 | Xray, spinal vertebrae              |           | A                  | 1              | Procedure | 60.00 | 1           | 60.00      |
| 5       | GXX18 | Hot/Cold Gel Pack                   |           | A                  | 1              | Good      | 15.00 | 1           | 15.00      |
| 6       | GXX21 | Lumbar Support (high)               |           | A                  | 1              | Good      | 55.00 | 1           | 55.00      |

Save Goods

Once you have a completed a list of goods and services click **Save Goods**.

Save a set of Goods and Services for reuse on another OCF18

Description

Acute patient

Recurrent patient

Description

New Patient

Save

Cancel

Type in a description, then click Save.

Type a name for this grouping. Click **Save**.

To choose a group for a new treatment plan click **Load Goods**.

The screenshot shows two overlapping windows. The background window is titled 'Part 12 Proposed Goods and Services' and contains a table with columns: G/S Ref, Code, Description, Attribute, Provider Reference, Estimate / Day, Quantity, Measure, Cost, Total Count, and Total Cost. The foreground window is titled 'Load a previously saved set of Goods and Services for an OCF18'. It has a 'Description' section with radio buttons for 'Acute patient', 'New Patient', and 'Recurrent patient'. Below this is a table with columns: Doctor, Code, Description, Quantity, Measure, Cost, and Total Cost. The table contains several rows of data, including 'Physical Rehabilitation', 'Manipulation, spinal vertebrae', 'Test, spinal vertebrae', 'Therapy, multiple body sites', 'Assessment (examination), tot', 'Xray, spinal vertebrae', and 'Hot/Cold Gel Pack'. At the bottom of the dialog, there is a 'Load these Goods and Services' button and a 'Cancel' button.

Click the description of the group and **Load these Goods and Services**. To view the contents of a saved group click the plus sign beside the description. Make any changes to practitioners or costs before completion.

## Part 12b Goods and Services Information

Type relevant information into part 12b.

The screenshot shows the 'Part 12b Goods and Services Information' window. It contains several sections: 'Estimated Duration of this Treatment Plan' with a text input field and 'weeks' label; 'How many treatment visits have you already provided:' with a text input field; 'Please indicate any additional comments regarding proposed goods and services:' with a large text area; 'Other Insurance Billing Information' with 'Ministry of Health (MOH) Total:' and 'Other Insurer 1 + 2 Total:' labels and input fields; and 'Attachments' with a radio button for 'Are there any attachments?' and options for 'No' and 'Yes'.

## Part 13 Signature of Applicant

The screenshot shows the 'Part 13 - Signature of Applicant' window. It contains a section 'Has the Insurer waived the requirement of the applicant's signature?' with radio buttons for 'No' and 'Yes'. Below this is a section 'Name of Applicant or Substitute Decision Maker' with 'Last Name' and 'First Name' labels and input fields. To the right of these fields is a checkbox for 'Signature on File' and a 'Signature Date' label with a dropdown menu showing '01/12/2010' and a 'clear' button.

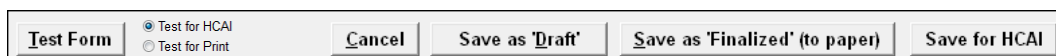
## Additional Comments



The Additional Comments tab is for attachment information if applicable or any other information to support the treatment plan. Up to 20,000 characters can be used in this field.

### Additional Buttons

Information regarding the buttons on the lower portion of the form can be found on page 25.



The signature on file and signature date boxes are required fields when sending forms electronically. Signatures are not transmitted to the insurer; however, hard copies of the form must be printed and signed and kept on file. To obtain signatures, the entire OCF should be completed. It is not advisable for health professionals or claimants to sign incomplete forms.

Print the completed ***draft*** form and have the claimant sign it.

## OCF21-B Auto Insurance Standard Invoice

The OCF 21 is completed by health care provider for the purpose of billing the automobile insurers for medical and rehabilitation goods and services. The OCF 21 has two versions.

Version B is used for billing insurers for services rendered after receiving approval of an OCF18 or when a response has not been received from the auto insurance company after 10 business days from submission of an OCF18.

From the patient information MVA tab you have two options for completion of the **OCF21 - New Invoice (OCF21)**, or **Create OCF21 from OCF18**:

- **New Invoice (OCF21)** is used when you do not have a finalized OCF18 in the patient file or when you want to change any existing information.
- **Create OCF21 from OCF18** is used when you are billing goods and services selected on the OCF18. This is the simplest and quickest way to complete an OCF21. Subsequent invoices require very few additions.

The screenshot shows the 'Patient Information' window for 'Lillian Smith' with the 'MVA' tab selected. The 'Accidents' table lists an accident with ID 102 on 8-Jan-2008 with Aviva Insurance Company of Canada. The 'Form Data' section has a tabbed interface with options: 'New Treatment Plan (OCF18)', 'New Invoice (OCF21)', 'New Assessment (OCF22)', 'New PAF (OCF23)', and 'Create OCF21 from OCF18'. The 'Form Data' table shows a record for accident 102, form 112 OCF18, submitted on April 4, 2008, with a final draft and invoice number 1. At the bottom, there are navigation buttons and a search section for a patient by last name, number, first name, or other.

Either OCF21 will produce the same tab, the only difference being in Part 7 on the 21B (detailed below).

The screenshot shows the 'MVA OCF-21' form. The top navigation bar includes 'Part 1/2', 'Part 3', 'Part 4', 'Part 5', 'Part 6', 'Part 7', 'Part 8', 'Summary', and 'Comments'. The 'Form Header' section contains 'Claim Number' (434454), 'Policy Number' (343344), and 'Date of Accident' (08/01/2008).   
**Part 1 - Applicant Information** includes fields for 'Last Name' (Smith), 'Middle Name', 'First Name' (Lillian), 'Address' (1545 Explorer Drive, Toronto, Ontario, L4Y 2E4), 'Date of Birth' (12/05/1981), 'Gender' (Female), 'City', 'Province', 'Postal Code', 'Telephone Number' ((416) 555-1212), and 'Extension'.   
**Part 2 - Insurance Company Information** includes 'Insurance Company Name' (TD General Insurance Company), 'City of Branch Office' (TDGI Etobicoke), 'Adjuster Last Name' (Brooker), 'Adjuster First Name' (Bob), 'Telephone Number' ((905) 555-8989), 'Extension' (55), 'Fax Number' ((905) 555-9696), and 'Name of Policy Holder' (Same as Applicant).   
 At the bottom, there are buttons for 'Test Form', 'Test for HCAI', 'Test for Print', 'Cancel', 'Save as Draft', 'Save as Finalized (to paper)', and 'Save for HCAI'.

Many of the OCF21 parts will populate with information from patient information, Accident ID, and information input in previous forms (if applicable). This makes completion of the OCF21 simple.

## Part 1 Applicant Information

|                                       |                     |                         |                                    |                                |                  |
|---------------------------------------|---------------------|-------------------------|------------------------------------|--------------------------------|------------------|
| <b>Part 1/2</b>                       |                     |                         |                                    |                                |                  |
| <b>Form Header</b>                    |                     |                         |                                    |                                |                  |
| Claim Number<br>434454                |                     | Policy Number<br>343344 |                                    | Date of Accident<br>08/01/2008 |                  |
| <b>Part 1 - Applicant Information</b> |                     |                         |                                    |                                |                  |
| Last Name<br>Smith                    |                     | Middle Name             |                                    | First Name<br>Lillian          |                  |
| Address<br>1545 Explorer Drive        |                     |                         |                                    | Date of Birth<br>12/05/1981    | Gender<br>Female |
| City<br>Toronto                       | Province<br>Ontario | Postal Code<br>L4Y 2E4  | Telephone Number<br>(416) 555-1212 | Extension                      |                  |

These fields will be populated from the Patient Information and Accident ID. Fields can be edited but changes to these fields will be reflected to fields where the information was pulled from. Fields where information will be updated are indicated by an underline.

## Part 2 Insurance Company Information

|  |                 |  |   |  |  |
|--|-----------------|--|---|--|--|
| <b>Part 2 - Insurance Company Information</b>          |                 |  |   |  |  |
| Insurance Company Name<br>TD General Insurance Company |                 |  | City of Branch Office<br>TDGI Etobicoke |  |  |
| Adjuster Last Name<br>Brooker                          |                 |  | Adjuster First Name<br>Bob              |  |  |
| Telephone Number<br>(905) 555-8989                     | Extension<br>55 | Name of Policy Holder<br><input checked="" type="checkbox"/> Same as Applicant |   |  |  |
| Fax Number<br>(905) 555-9696                           |                 |  |   |  |  |

Insurance Company Information is populated from previous forms or can be selected from the drop down lists.



If you are submitting OCF forms through the PMP HCAI interface the insurer list will be updated every time you connect to HCAI.

## Part 3 Invoice Information

|  |             |                               |   |   |  |
|--|-------------|-------------------------------|---|---|--|
| <b>Part 3</b>  |             |                               |   |   |  |
| <b>Part 3 - Invoice Information</b>  |             |                               |   |   |  |
| <b>Invoice details</b>   |             |                               |   |   |  |
| Invoice Number assigned at finalization.   |             | First Invoice<br>Last Invoice | <input type="radio"/> No<br><input type="radio"/> Yes | <input type="radio"/> Yes<br><input type="radio"/> No |  |
| For previously approved goods and services, please complete the following:         |             |                               |   |   |  |
| Type of Plan, PAF or Minor Injury Guideline<br>Minor Injury Guideline or PAF (210) |             | Type<br>Minor Injury          |   |   |  |
| Plan Date  | Plan Number | Approved Amount               | Previously Billed                                     |   |  |



Make selections and type required information. The Plan Date is listed in Part 5 of the approved OCF18. Plan Number is found on the main MVA screen under the Plan Number column.

Choose the **Type of Plan** as *21B - Treatment Plan*. Sections of this form change depending on the Type of Plan chosen.

## Part 4 Payee Information

| Part 4 - Payee Information           |                      |  |  |
|--------------------------------------|----------------------|--|--|
| Last Name<br>Palmer                  | First Name<br>Daniel | Payee Number   |  |
| Facility Name                        |                      | AISI Facility Number   |  |
| Address<br>20 Victoria St, Suite 200 |                      |  |  |
| City<br>Toronto                      | Province<br>Ontario  | Postal Code<br>M5C 2N8   |  |
| Telephone Number<br>(416) 860-0700   | Extension            | Fax Number<br>(416) 860-0857   |  |
| Email Address                        |                      | <input checked="" type="checkbox"/> Signature on File<br>Signature Date <span>clear</span><br>14/12/2010 |  |

Type required information.

## Part 5 Injury and Sequelae Information

| Part 5 - Injury and Sequelae Information                                     |                    |
|--|--------------------|
| <b>Injury 1</b> <span>clear</span><br>Injury Description (Primary Complaint) | ICD-10 Injury Code |
| <b>Injury 2</b> <span>Clear</span><br>Injury Description                     | ICD-10 Injury Code |
| <b>Injury 3</b> <span>Clear</span><br>Injury Description                     | ICD-10 Injury Code |

Part 5 will be populated with information input into a previous OCF form. Refer to page 30 for information on selecting ICD-10-CA codes.

## Part 6 Other Health Providers

| Part 6 - Other Health Providers                   |            |           |             |                     |             |             |  |
|---|------------|-----------|-------------|---------------------|-------------|-------------|--|
| Doctor  | First Name | Last Name | Provider ID | College Reg. Number | AISI Number | Hourly Rate |  |
| <b>A</b> <span>DD</span> <span>clear</span><br>DC | Daniel     | Palmer    | 817         | 4444                |             |             |  |
| <b>B</b> <span>clear</span>                       |            |           |             |                     |             |             |  |
| <b>C</b> <span>clear</span>                       |            |           |             |                     |             |             |  |

Part 6 will populate from information input into a previous OCF form or choose practitioners from the PMP list below **Doctor**.



If the provider is not included on the drop down list under **Doctor** type the practitioner details into all remaining fields, leaving the first field blank.

Part 7      Reimbursable Goods and Services



Part 7B is used when billing the auto insurer for all goods and services other than Minor Injury Guidelines.

| Date | Provider Reference | Code  | Description                    | Attribute | Quantity | Measure   | Cost |
|------|--------------------|-------|--------------------------------|-----------|----------|-----------|------|
|      | A                  | 1SC05 | Manipulation, spinal vertebrae |           | 1        | Procedure | 0.00 |

Buttons: Add, Delete, Save, Apply Codes from Plan, Duplicate this Line Item

Details:

| Date | Quantity | Measure   | Unit Cost | Cost | HST  |
|------|----------|-----------|-----------|------|------|
|      | 1        | Procedure | 0         | 0.00 | 0.00 |

- For the **New OCF 21** form select goods and services by clicking **Add** to choose CCI and GAP codes from the CCI Code Selector as detailed on page 33 and then using the **Duplicate this Line Item** button.
- For the **OCF 21 from 18** form select goods and services by choosing **Apply Codes from Plan**.

Add and Duplicate this Line Item

Click **Add** to select an item from the CCI Code Selector. Edit the date, fee, and practitioner. If this item was rendered more than once during the invoice period click **Duplicate this Line Item**.

| Date        | Provider Reference | Code  | Description                       | Attribute | Quantity | Measure   | Cost  |
|-------------|--------------------|-------|-----------------------------------|-----------|----------|-----------|-------|
| 11 Feb 2008 | A                  | 1ZX05 | Manipulation, multiple body sites |           | 1        | Procedure | 30.00 |

Buttons: Add, Delete, Save, Apply Codes from Plan, Duplicate this Line Item

Details:

| Date        | Quantity | Measure   | Unit Cost | Cost  | HST  |
|-------------|----------|-----------|-----------|-------|------|
| 11 Feb 2008 | 1        | Procedure | 30        | 30.00 | 0.00 |

Click on the calendar to select the dates for each service. Chosen dates will appear on the right. To remove a selected date click it again. Once you have selected all dates for this item click **OK**. You will be returned to Part 7 where you can choose another code for duplication.

### Apply Codes from Plan

Choose **Apply Codes from Plan**. The Blue titlebar at the top of each set of calendars show the services assigned on the Treatment Plan. Click on the calendar to select the dates for each service. Chosen dates will appear on the right. To remove a selected date click it again. Scroll through the list to choose each good and services provided to the patient during the invoicing period. Click **OK**.

The screenshot shows the 'MVAApplyCodes' dialog box with three service items:

- Item 1:** 1ZK12 Therapy, multiple body sites. Provider: Laurel Hardy. Total Count: 24. Quantity: 0.00 SN. Calendar shows dates from Feb 08 to Feb 29, 2008. Selected dates are highlighted in green.
- Item 2:** 22Z02 Assessment (examination), total body. Provider: Daniel Palmer. Total Count: 1. Quantity: 1.00 PR. Calendar shows dates from Feb 08 to Feb 08, 2008. Selected date is highlighted in green.
- Item 3:** 22Z02 Assessment (examination), total body. Provider: Daniel Palmer. Total Count: 1. Quantity: 1.00 PR. Calendar shows dates from Feb 08 to Feb 08, 2008. Selected date is highlighted in green.

Items chosen from the Treatment Plan now populate the Goods and Services tab. Edit items as required.

| B Part 7                                 |                    |       |                                     |           |          |           |       |
|--|--------------------|-------|-------------------------------------|-----------|----------|-----------|-------|
| Part 7 - Reimbursable Goods and Services |                    |       |                                     |           |          |           |       |
| Date                                     | Provider Reference | Code  | Description                         | Attribute | Quantity | Measure   | Cost  |
| 07 Feb 2008                              | C                  | 1ZX12 | Therapy, multiple body sites        |           | 1        | Procedure | 80.00 |
| 08 Feb 2008                              | A                  | 22Z02 | Assessment (examination), total bod |           | 1        | Procedure | 75.00 |
| 11 Feb 2008                              |                    | SZZPR | Physical Rehabilitation             |           | 1        | Session   | 30.00 |
| 15 Feb 2008                              |                    | SZZPR | Physical Rehabilitation             |           | 1        | Session   | 30.00 |
| 18 Feb 2008                              |                    | SZZPR | Physical Rehabilitation             |           | 1        | Session   | 30.00 |
| 21 Feb 2008                              | C                  | 1ZX12 | Therapy, multiple body sites        |           | 1        | Procedure | 80.00 |
| 22 Feb 2008                              |                    | SZZPR | Physical Rehabilitation             |           | 1        | Session   | 30.00 |
| 25 Feb 2008                              |                    | SZZPR | Physical Rehabilitation             |           | 1        | Session   | 30.00 |
| 29 Feb 2008                              |                    | SZZPR | Physical Rehabilitation             |           | 1        | Session   | 30.00 |

## Part 8 Other Insurance

Complete this section if the patient has additional coverage.

The screenshot shows the 'B Part 8' form for 'Other Insurance'. It includes sections for 'Other Insurer 1' and 'Other Insurer 2', each with fields for Insurer Name, Insurance Plan or Policy Number, Name of Plan Member (Last Name, First Name), and Insurer's Identifier.

**Other Insurer 1:**

- Is there other insurance coverage for any goods and services listed in this Treatment Plan? ☐ No ☒ Yes
- Is there Ministry of Health (MOH) coverage for any goods and services in this Treatment Plan? ☐ No ☐ Yes ☒ Not Applicable
- Insurer Name: \_\_\_\_\_ Insurance Plan or Policy Number: \_\_\_\_\_
- Name of Plan Member: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Insurer's Identifier: \_\_\_\_\_

**Other Insurer 2:**

- Insurer Name: \_\_\_\_\_ Insurance Plan or Policy Number: \_\_\_\_\_
- Name of Plan Member: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Insurer's Identifier: \_\_\_\_\_

Summary

Summary

Invoice Summary

Other Insurance (for goods and services on this invoice)

|                     | MOH  | Insurer 1 | Insurer 2 |
|---------------------|------|-----------|-----------|
| Chiropractic:       |      |           |           |
| Physiotherapy:      |      |           |           |
| Massage Therapy:    |      |           |           |
| Other Service Type: |      |           |           |
| Total:              | 0.00 | 0.00      | 0.00      |

Account Activity Since Last Invoice

☐ Is Interest Charged?

Prior Balance :

Payment Received from Auto Insurer:

Overdue Amount : 0.00

Attachments

Are there any attachments? ☒ No ☐ Yes

Total

Goods and Services Subtotal:

MOH:

Other Insurer 1+2:

HST @13% :

N/A

Interest:

Auto Insurer Total :

Other Information

Make Cheque payable to :

Other Information:

Add *Other Insurance* amounts and *Account Activity Since Last Invoice* if applicable. The *Total* fields will populate and calculate automatically from information input in Goods and Services fields.

Comments

Comments

Additional Comments

The Comments tab is for attachment information if applicable or any other information to support the treatment plan. Up to 20,000 characters can be used in this field.

Additional Buttons

The bottom portion of the form contains the following buttons:

Test Form

☒ Test for HCAI  
☐ Test for Print

Cancel

Save as 'Draft'

Save as 'Finalized' (to paper)

Save for HCAI

Details can be found on page 25.

## OCF21- C Auto Insurance Standard Invoice

The OCF 21 is completed by health care provider for the purpose of billing the automobile insurers for medical and rehabilitation goods and services. The OCF 21 has two versions. Version C is used when billing services rendered through the Minor Injury Guideline (MIG) or Pre-Approved Framework (PAF).

From the patient information MVA tab you have two options for completion of the **OCF21 - New Invoice (OCF21)**, or **Create OCF21 from OCF23**:

- **New Invoice (OCF21)** is used when you do not have a finalized OCF23 in the patient file or when you want to change any existing information.
- **Create OCF21 from OCF23** is used when you are billing goods and services selected on the OCF23. This is the simplest and quickest way to complete an OCF21. Subsequent invoices require very few additions.

The screenshot shows the 'Patient Information - 2 - Lillian Smith' window. The 'MVA' tab is selected. Under 'Accidents', there is a table with one row: Accident ID 102, Comments, Date 8-Jan-2008, Insurance Company Name Aviva Insurance Company of Canada. Below this is a 'Form Data' section with four tabs: 'New Treatment Plan (OCF18)', 'New Invoice (OCF21)', 'New Assessment (OCF22)', and 'Now PAF (OCF23)'. The 'New Invoice (OCF21)' tab is selected, showing a table with columns: Accident ID, Form ID, Form Type, Comments, Date, Draft/Final, Plan Number, and Invoice Number. The table contains one row: 102, 112 OCF18, Submitted April 4, 4-Apr-2008, Final, 1, 1. At the bottom, there are buttons for 'Next', 'Previous', 'Save', 'Cancel', 'New Patient', and a 'Search for a Patient by' section with fields for 'Last name', 'Number', 'First name', and 'Other', and a 'Continue' button.

Either OCF21 will produce the same tab, the only difference being in Part 7 on the 21B (detailed below).

The screenshot shows the 'MVA OCF-21' form. The 'Form Header' section includes 'Claim Number' (434454), 'Policy Number' (343344), and 'Date of Accident' (08/01/2008). The 'Part 1 - Applicant Information' section includes 'Last Name' (Smith), 'Middle Name', 'First Name' (Lillian), 'Address' (1545 Explorer Drive), 'City' (Toronto), 'Province' (Ontario), 'Postal Code' (L4Y 2E4), 'Telephone Number' ((416) 555-1212), and 'Extension'. The 'Part 2 - Insurance Company Information' section includes 'Insurance Company Name' (TD General Insurance Company), 'Adjuster Last Name' (Brooker), 'Telephone Number' ((905) 555-8989), 'Extension' (55), 'Fax Number' ((905) 555-9696), 'City of Branch Office' (TDGI Etobicoke), 'Adjuster First Name' (Bob), and a checkbox for 'Same as Applicant'. At the bottom, there are buttons for 'Test Form', 'Test for HCAI', 'Test for Print', 'Cancel', 'Save as "Draft"', 'Save as "Finalized" (to paper)', and 'Save for HCAI'.

Many of the OCF21 parts will populate with information from patient information, Accident ID, and information input in previous forms (if applicable). This makes completion of the OCF21 simple.

## Part 1 Applicant Information

|                                       |                     |                             |                                    |                                |  |
|---------------------------------------|---------------------|-----------------------------|------------------------------------|--------------------------------|--|
| Part 1/2                              |                     |                             |                                    |                                |  |
| <b>Form Header</b>                    |                     |                             |                                    |                                |  |
| Claim Number<br>434454                |                     | Policy Number<br>343344     |                                    | Date of Accident<br>08/01/2008 |  |
| <b>Part 1 - Applicant Information</b> |                     |                             |                                    |                                |  |
| Last Name<br>Smith                    |                     | Middle Name                 |                                    | First Name<br>Lillian          |  |
| Address<br>1545 Explorer Drive        |                     | Date of Birth<br>12/05/1981 |                                    | Gender<br>Female               |  |
| City<br>Toronto                       | Province<br>Ontario | Postal Code<br>L4Y 2E4      | Telephone Number<br>(416) 555-1212 | Extension                      |  |

These fields will be populated from the Patient Information and Accident ID. Fields can be edited but changes to these fields will be reflected to fields where the information was pulled from. Fields where information will be updated are indicated by an underline.

## Part 2 Insurance Company Information

|  |                 |  |  |
|--|-----------------|--|--|
| <b>Part 2 - Insurance Company Information</b>          |                 |  |  |
| Insurance Company Name<br>TD General Insurance Company |                 | City of Branch Office<br>TDGI Etobicoke  |  |
| Adjuster Last Name<br>Brooker                          |                 | Adjuster First Name<br>Bob   |  |
| Telephone Number<br>(905) 555-8989                     | Extension<br>55 | Name of Policy Holder<br><input checked="" type="checkbox"/> Same as Applicant |  |
| Fax Number<br>(905) 555-9696                           |                 |  |  |

Insurance Company Information is populated from previous forms or can be selected from the drop down lists.



If you are submitting OCF forms through the PMP HCAI interface the insurer list will be updated every time you connect to HCAI.

## Part 3 Invoice Information

|  |                            |  |  |
|--|----------------------------|--|--|
| Part 3   |                            |  |  |
| <b>Part 3 - Invoice Information</b>  |                            |  |  |
| <b>Invoice details</b>   |                            |  |  |
| Invoice Number assigned at finalization.   | First Invoice Last Invoice | <input checked="" type="radio"/> No<br><input checked="" type="radio"/> No | <input type="radio"/> Yes<br><input type="radio"/> Yes |
| For previously approved goods and services, please complete the following:         |                            |  |  |
| Type of Plan, PAF or Minor Injury Guideline<br>Minor Injury Guideline or PAF (21C) | Type<br>Minor Injury       |  |  |
| Plan Date<br>clear   | Plan Number<br>clear       | Approved Amount  | Previously Billed                                      |

Make selections and type required information. The Plan Date is listed in Part 5 of the approved OCF18. Plan Number is found on the main MVA screen under the Plan Number column.

Choose the **Type of Plan** as 21C - *Minor Injury Guideline* or PAF (for accidents prior to September 1, 2010 than meet that PAF Guidelines). Sections of this form will change depending on the Type of Plan chosen.

## Part 4 Payee Information

Type required information.

## Part 5 Injury and Sequelae Information

Part 5 will be populated with information input into a previous OCF form. Refer to page 30 for information on selecting ICD-10-CA codes.

## Part 6 Other Health Providers

Part 6 will populate from information input into a previous OCF form or choose practitioners from the PMP list below **Doctor**.



If the provider is not included on the drop down list under **Doctor** type the practitioner details into all remaining fields, leaving the first field blank.

Part 7 Goods and Services Rendered



Part 7C is used when billing for services rendered through the Minor Injury Guideline.

Click **Add** to select an item from the CCI Code Selector. Edit the date, fee, and practitioner. If this item was rendered more than once during the invoice period click **Duplicate this Line Item**.

C Part 7

Part 7 - Goods and Services Rendered

| Date | Provider Reference | Code  | Description                    | Attribute | Quantity | Measure   |
|------|--------------------|-------|--------------------------------|-----------|----------|-----------|
| *    | A                  | 1SC05 | Manipulation, spinal vertebrae |           | 1        | Procedure |

◀ ◁ ▷ ▶

AddDeleteSave

Edit Goods and Services Line Item

Duplicate this Line Item

CodeDescriptionAttributeProvider Ref

1SC05Manipulation, spinal vertebraeProcedureA> Daniel Palmer

Details

DateQuantityMeasure

1

Procedure

Click on the calendar to select the dates for each service. Chosen dates will appear on the right. To remove a selected date click it again. Once you have selected all dates for this item click **OK**. You will be returned to Part 7 where you can choose another code for duplication.

B Part 7

Part 7 - Reimbursable Goods and Services

| Date        | Provider Reference | Code  | Description                       | Attribute | Quantity | Measure   | Cost  |
|-------------|--------------------|-------|-----------------------------------|-----------|----------|-----------|-------|
| 11 Feb 2008 | A                  | 12X05 | Manipulation, multiple body sites |           | 1        | Procedure | 30.00 |

Select Multiple Dates

◀◀Feb 2008Sun Mon Tue Wed Thu Fri Sat

12345678910111213141516171819202122232425262728293031

Mar 2008Sun Mon Tue Wed Thu Fri Sat

12345678910111213141516171819202122232425262728293031

Apr 2008Sun Mon Tue Wed Thu Fri Sat

123456789101112131415161718192021222324252627282930

Feb 13, 2008Feb 15, 2008Feb 18, 2008Feb 20, 2008Feb 22, 2008Feb 25, 2008

CancelOK

Details

DateQuantityMeasureUnit Cost\*CostHST

11 Feb 2008

1

Procedure

30

30.00

0.00

Part 8 Reimbursable Fees within the Guidelines

C Part 8

Part 8 - Reimbursable Fees Within the Guidelines:

| Code  | Description               | Attribute | Cost   |
|-------|---------------------------|-----------|--------|
| MIG00 | Initial Visit (1 session) |           | 215.00 |
| MIG01 | Block 1 (weeks 1-4)       |           | 775.00 |

◀ ◁ ▷ ▶

AddDeleteSave

Edit Goods and Services Line Item

CodeDescriptionAttributeCost

MIG01Block 1 (weeks 1-4)775.00

Input all pre-approved fees.

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## Summary

**Summary**

**Invoice Summary**

Other Insurance (for goods and services on this invoice)

|                     | MOH  | Insurer 1 | Insurer 2 |
|---------------------|------|-----------|-----------|
| Chiropractic:       |      |           |           |
| Physiotherapy:      |      |           |           |
| Massage Therapy:    |      |           |           |
| Other Service Type: |      |           |           |
| <b>Total:</b>       | 0.00 | 0.00      | 0.00      |

**Account Activity Since Last Invoice**

☐ Is Interest Charged?

Prior Balance :

Payment Received from Auto Insurer:

Overdue Amount :

**Attachments**

Are there any attachments? ☒ No ☐ Yes

**Total**

**Goods and Services Subtotal:**

**MOH:**

**Other Insurer 1+2:**

**HST @13% :**

**N/A**

**Interest:**

**Auto Insurer Total :**

**Other Information**

**Make Cheque payable to :**

**Other Information:**

Add *Other Insurance* amounts and *Account Activity Since Last Invoice* if applicable. The *Total* fields will populate and calculate automatically from information input in Goods and Services fields.

## Comments

The Comments tab is for attachment information if applicable or any other information to support the treatment plan. Up to 20,000 characters can be used in this field.

**Comments**

**Additional Comments**

## Additional Buttons

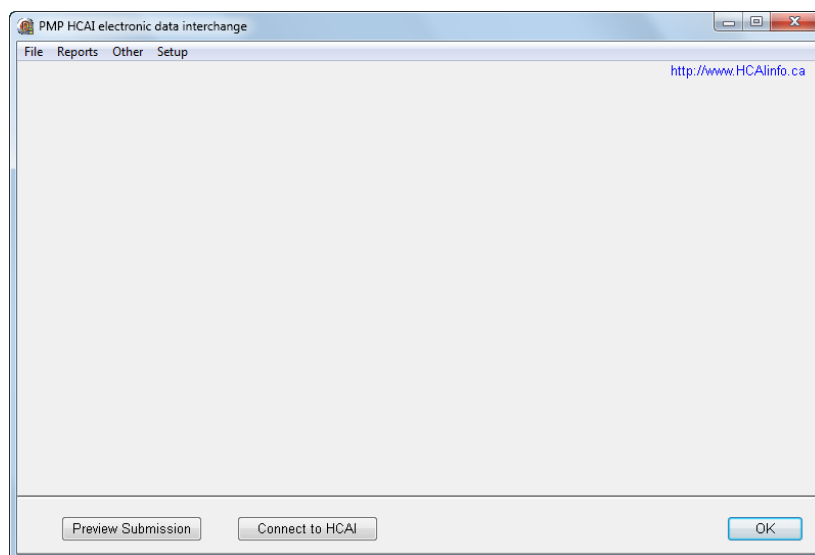
The bottom portion of the form contains the following buttons:

☒ Test for HCAI ☐ Test for Print

Details can be found on page 25.

# PMP HCAI Electronic Data Interchange

## Main PMP HCAI Screen



The main screen has menus across the top and buttons at the bottom. The middle area of the screen will populate with communication messages once you connect to HCAI.

## Preview Submission

The **Preview Submission** button enables you to view the forms within the batch that will be sent to HCAI once you click **Connect to HCAI**. Choose this button to view the submission. Click **Run the Report**.

| Fri, 28 May 2010 |             | Submission Preview |                      |       |         | Page No. 1      |
|------------------|-------------|--------------------|----------------------|-------|---------|-----------------|
| Doctor           | Form Date   | Patient No.        | Patient Name         | OCFx  | Form ID | Report Comments |
| DD               | 28-May-2010 | 1                  | Adrienne Linton      | OCF21 | 145     |                 |
| DD               | 28-May-2010 | 4                  | Agnes Seale          | OCF18 | 182     |                 |
| DD               | 28-May-2010 | 18                 | Alexander Lloyd      | OCF18 | 132     |                 |
| DD               | 28-May-2010 | 51                 | Amber Liondra Linton | OCF18 | 135     |                 |
| DD               | 28-May-2010 | 1306               | Robert Allan Linton  | OCF23 | 138     |                 |

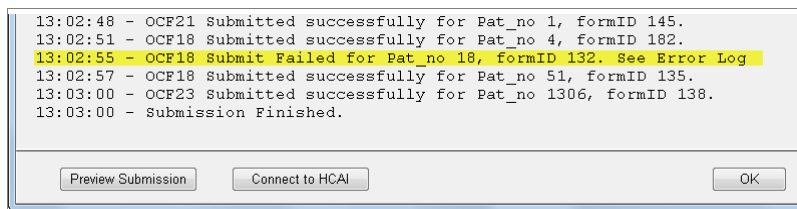
If you choose to remove a form from the submission go back into the patient file in PMP. On the MVA tab, click the form then **Edit**. Once the form is open choose **Save as Draft**. This returns the form to 'draft' mode and will remove it from the submission.

## Connect to HCAI

The **Connect to HCAI** button links your computer to the HCAI system. Enter your PMS password. The interface will now:

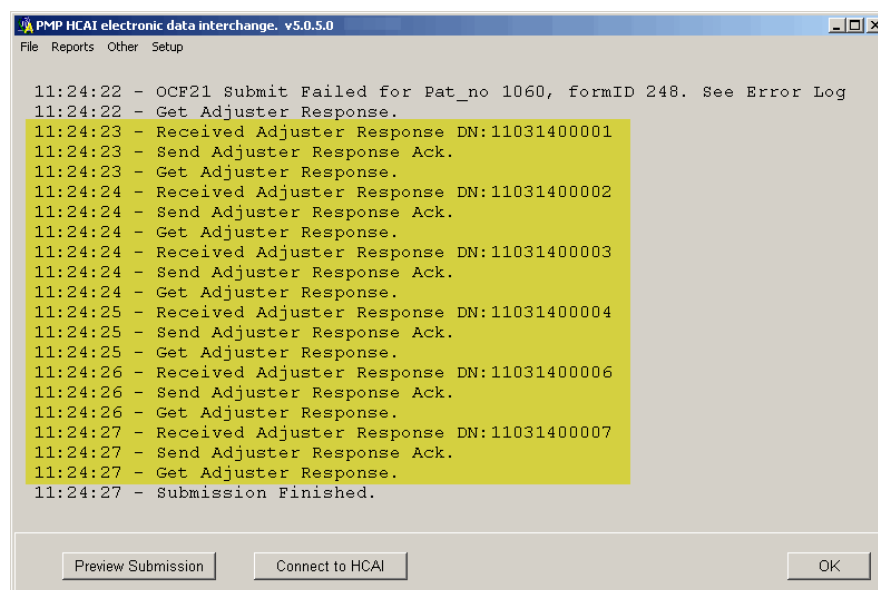
- **Facility information is verified and updated.** The facility information details the information that you have listed with HCAI. Any update or changes would appear on the report
- **Update insurer's list in Insurers are updated in PMP.** This procedure retrieves an updated list of auto insurers and inputs the list into PMP
- **Completed OCF forms are sent to HCAI.** The batch file containing the forms with a HCAI status of *Ready to Submit* is sent to HCAI.
- **Adjudicator responses are retrieved.** Each adjudication response will be retrieved individually and listed separately on the communication screen.

Once you input your password the screen will populate with transfer and communication information. Read the screen. You will see communication referring to your submissions and adjudications.

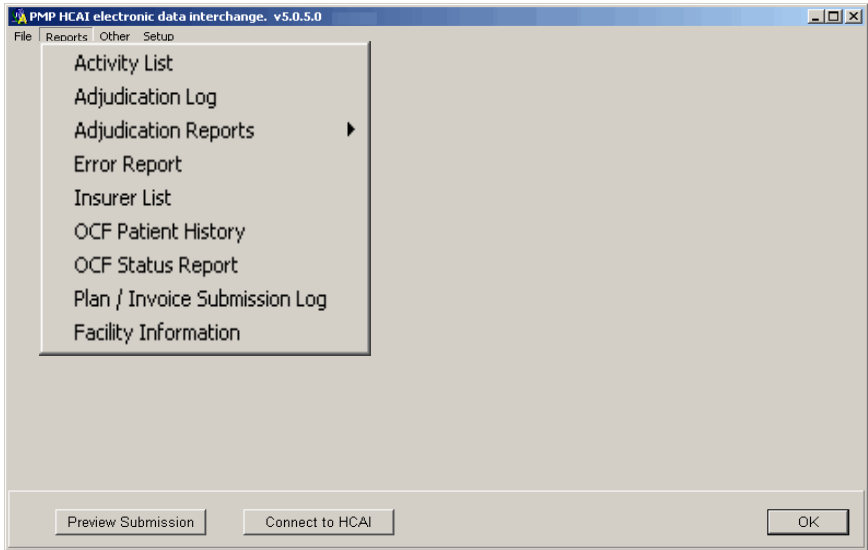


A line item will appear for each form submitted informing you of the status. The highlighted line item in the screen shot above is a failed submission and refers the user to see the Error Log.

The screen below has highlighted the Adjudication responses.



# Reports



The Reports menu supplies you with tools required to:

- review what forms were submitted
- why forms were rejected
- what claims got adjudicated
- the status of forms

Many forms allow you to select ‘filters’ which can assist in locating specific information.

## Activity List

The Activity list will produce a document of all communication with HCAI. This report is dependant upon the user first connecting to HCAI to retrieve the activity list. Accomplish this by going to the **Other** menu and selecting **Get Activity List**. You made need to enter your PMP Password. A connection is established and the list retrieved. Now select the **Reports** menu followed by **Activity List**.

| Wed, 16 Mar 2011 |             | <b>Activity List</b> |                |                 | <b>Date From:</b> 14-Feb-2011 | <b>Date To:</b> 14-Mar-2011 |            |
|------------------|-------------|----------------------|----------------|-----------------|-------------------------------|-----------------------------|------------|
| Date             | Time        | Form ID              | Patient Number | Document Source | Document Number               | Document Status             | Net Amount |
| 09-Mar-2011      | 4:15:00 pm  | 134                  | 18             | PMS             | 11030900008                   | Declined                    | 0.00       |
| 11-Mar-2011      | 10:43:00 am | 112                  | 1322           | PMS             | 11031100001                   | Submitted                   | 0.00       |
| 11-Mar-2011      | 10:51:00 am | 114                  | 1032           | PMS             | 11031100002                   | Submitted                   | 0.00       |
| 11-Mar-2011      | 11:21:00 am | 223                  | 857            | PMS             | 11031100003                   | Approved                    | 1,375.00   |
| 11-Mar-2011      | 11:21:00 am | 224                  | 864            | PMS             | 11031100004                   | Approved                    | 2,015.00   |
| 11-Mar-2011      | 11:21:00 am | 225                  | 984            | PMS             | 11031100005                   | PartiallyApproved           | 1,860.00   |
| 11-Mar-2011      | 11:21:00 am | 226                  | 1022           | PMS             | 11031100006                   | Approved                    | 428.65     |
| 11-Mar-2011      | 11:25:00 am | 227                  | 1584           | PMS             | 11031100007                   | Approved                    | 1,200.00   |
| 11-Mar-2011      | 3:52:00 pm  | 219                  | 13             | PMS             | 11031100008                   | Submitted                   | 0.00       |
| 11-Mar-2011      | 3:52:00 pm  | 220                  | 13             | PMS             | 11031100009                   | Submitted                   | 0.00       |
| 11-Mar-2011      | 3:52:00 pm  | 221                  | 778            | PMS             | 11031100010                   | Submitted                   | 0.00       |
| 11-Mar-2011      | 3:52:00 pm  | 222                  | 1500           | PMS             | 11031100011                   | Submitted                   | 0.00       |
| 14-Mar-2011      | 10:24:00 am | 243                  | 18             | PMS             | 11031400001                   | Approved                    | 50.00      |
| 14-Mar-2011      | 10:24:00 am | 246                  | 484            | PMS             | 11031400002                   | Approved                    | 1,850.00   |

## Adjudication Log

The Adjudication Log lists all items retrieved from HCAI that have been adjudicated by the insurer. This report refers specifically to items retrieved. View the Adjudication Reports for specific details.

**Adjudication Log**

Date From: Today Date To: 10-Mar-2011

Report Destination: ☒ Screen ☐ Printer ☐ Export to RTF ☐ Save to File **Run the Report**

Thu, 10 Mar 2011 **Adjudication Log** Date From: 24-Feb-2011 Date To: 10-Mar-2011 Page No. 1

| Date        | Time        | Message ID                           | HCAI PMS Username | Document Number | OCFx  | Form ID | Patient No. |
|-------------|-------------|--------------------------------------|-------------------|-----------------|-------|---------|-------------|
| 01-Mar-2011 | 4:30:18 pm  | 27DA46F6-463E-492A-9D23-5717169933C5 | James             | 11021500011     | OCF18 | 200     | 0           |
| 01-Mar-2011 | 4:30:22 pm  | AB9425B3-04C4-4EFA-8280-EDE80EDA67C6 | James             | 11022300002     | OCF21 | 216     | 0           |
| 01-Mar-2011 | 4:30:24 pm  | D7FCB469-F767-4746-9081-505B46425A15 | James             | 11020400004     | OCF21 | 220     | 0           |
| 01-Mar-2011 | 4:30:26 pm  | 3E362D65-5AE6-4462-AED7-DDF80E1D63AB | James             | 11020400003     | OCF21 | 219     | 0           |
| 10-Mar-2011 | 10:10:38 am | 563E864C-4501-48BC-9026-A9111AFFA78F | James             | 11030900004     | OCF23 | 138     | 1306        |
| 10-Mar-2011 | 10:10:42 am | 5FEBD972-5081-4F62-A16C-83BFB7EC8DAF | James             | 11030900006     | OCF21 | 221     | 18          |
| 10-Mar-2011 | 10:10:46 am | 5A62CA54-3AAA-4EEB-B17D-FE38A78B44C9 | James             | 11030900007     | OCF21 | 220     | 1306        |
| 10-Mar-2011 | 10:10:50 am | CF541FA2-4275-43EC-9BF7-E1335DB50212 | James             | 11030900008     | OCF18 | 134     | 18          |

## Adjudication Reports

The **Adjudication Reports** are broken into type; **OCF 18, 21 and 23**. This is the same report that is viewed using the **View Adjudication** button offered in the patient file.

The report can be condensed with filters to allow viewing of only the required information. The **Filter by Download Date** will default to the last date that adjudication responses were retrieved from HCAI. The report can be printed in a continuous stream or you can each adjudication response start on a new page by placing a checkmark on the **Print one form per page** option.

**Adjudication Report OCF-21**

Choose the optional filters to condense the report.

☐ Filter by this Patient only: Besenyi, Alan

☐ Filter by Form Date: Date From: 01-Jan-2010 Date To: 15-Mar-2011

☒ Filter by Download Date: Date From: 14-Mar-2011 Date To: 14-Mar-2011

☐ Filter by Adjudication Result: ☐ Approved ☐ Partially Approved ☐ Declined

Sort order: ☒ order by Patient Name ☐ order by Patient Number ☐ order by HCAI Document Number ☐ order by Doctor, Patient Name

☒ Print one form per page

Report Destination: ☒ Screen ☐ Printer ☐ Export to RTF ☐ Save to File **Run the Report**

Adjudication Reports have a header that detail the form details. The Goods and services section of the report is representative of the goods and services on your OCF form.

Your OCF18 - Goods & Services

| G/S Ref | Description                     | †Code | †Attribute | Provider Ref | Estimate/day |          |       | Projected   |            |
|---------|---------------------------------|-------|------------|--------------|--------------|----------|-------|-------------|------------|
|         |                                 |       |            |              | Quantity     | †Measure | Cost  | Total Count | Total Cost |
| 1       | Physical Rehabilitation         | SZZPR |            |              |              | SN       | 35.00 | 10          | 350.00     |
|         | Manipulation, spinal vertebrae  | 1SC05 |            | A            | 1            | PR       | 30.00 |             |            |
|         | Test, total body                | 2ZZ08 |            | A            | 1            | PR       | 5.00  |             |            |
| 2       | Therapy, multiple body sites    | 1ZX12 |            | B            | 1            | PR       | 80.00 | 10          | 800.00     |
| 3       | Assessment (examination), total | 2ZZ02 |            | A            | 1            | PR       | 75.00 | 1           | 75.00      |
| 4       | Xray, spinal vertebrae          | 3SC10 |            | A            | 1            | PR       | 65.00 | 1           | 65.00      |
| 5       | Assistance, personal care       | 7SC01 |            | A            | 1            | HR       | 45.00 | 1           | 45.00      |

Part 12 Proposed Goods or Services Requiring Insurer Approval  
To the extent possible, this Treatment and Assessment Plan

Insurer Adjudication Report

Wed, 16 Mar 2011      **Adjudication Report OCF-18**      Date From: BC      Page No. 1  
 Date To: 16-Mar-2011

| Pat. No. | 1507                                 | Patient Name | King, Maria | Doctor                       | Dr. Joe OCChiro | Document Status        | Approved    |
|----------|--------------------------------------|--------------|-------------|------------------------------|-----------------|------------------------|-------------|
| Date     | 14-Mar-2011                          | FormID       | 240         | Adjudication Document Number | 11031400006     | OCF-18 Document Number | 11031400004 |
| Code     | Description                          | Provider     | Quantity    | Cost                         | Total Count     | Total Cost             |             |
| SZZPR    | Physical Rehabilitation              |              | 0.00        | SN                           | 35.00           | 10                     | 350.00      |
| 1ZX12    | Therapy, multiple body sites         | B            | 1.00        | PR                           | 80.00           | 10                     | 800.00      |
| 2ZZ02    | Assessment (examination), total body | A            | 1.00        | PR                           | 75.00           | 1                      | 75.00       |
| 3SC10    | Xray, spinal vertebrae               | A            | 1.00        | PR                           | 65.00           | 1                      | 65.00       |
| 7SC01    | Assistance, personal care            | A            | 1.00        | HR                           | 45.00           | 1                      | 45.00       |
|          |                                      |              |             | Proposed                     | Approved        | Adjuster Response      |             |
|          |                                      |              |             | Sub-Total                    | 1,335.00        | 1,335.00               |             |
|          |                                      |              |             | Minus MOH                    | 0.00            | 0.00                   |             |
|          |                                      |              |             | Minus Other Insurer 1 + 2    | 0.00            | 0.00                   |             |
|          |                                      |              |             | TAX (if applicable)          | 104.00          | 104.00                 |             |
|          |                                      |              |             | Auto Insurer Total           | 1,439.00        | 1,439.00               |             |



All adjudication details this report were supplied by the insurer. If you require additional information you should contact the insurer directly.

## Error Report

Retrieve the error log for the **Reports** menu, **Error Report**.

The date from option offers you a **Today** button to simplify locating specific errors. Choose the date range and select **Run the Report**.

**Error Report**

Date From: Today      Date To: 28/05/2010

Report Destination: ☒ Screen    ☐ Printer    ☐ Export to RTF    ☐ Save to File

Run the Report

Locate the rejection on the document. The report is created by rejected information from the HCAI system. Any line information that says 'Erroneous value' refers to the information that was typed into the rejected field. The Failed rejection information will notify you as to where the problem lies.

| Fri, 28 May 2010  |             | <b>Error Log</b>                     |                          | <b>Date From:</b> 28-May-2010 | Page No. |
|---|-------------|--------------------------------------|--------------------------|-------------------------------|----------|
|   |             |                                      |                          | <b>Date To:</b> 28-May-2010   |          |
| <u>Date</u>   | <u>Time</u> | <u>Message ID</u>                    | <u>HCAI PMS Username</u> |                               |          |
| 28 May 2010   | 1:02:55 pm  | CDC19E2C-E815-4C34-8277-A8DF6DE4DA68 | James                    |                               |          |
| OCF18 Submit Failed for Pat_no 18, formID 132.                      |             |                                      |                          |                               |          |
| Provider is invalid for specified facility. Erroneous value was 17. |             |                                      |                          |                               |          |

Correct the rejected form by returning to patient file in PMP and going to the MVA tab. The form will now have a HCAI status of *Submit Errors*. Click the form and then **Edit**. Resolve the conflict and choose **Save as HCAI**. The form will now be sent with the next submission.

| Form Data                         |         |                           |               |                        |             |                 |          |                       |                |
|-----------------------------------|---------|---------------------------|---------------|------------------------|-------------|-----------------|----------|-----------------------|----------------|
| New Treatment Plan (OCF18)        |         | New Invoice (OCF21)       |               | New Assessment (OCF22) |             | New PAF (OCF23) |          | Create OCF21 from OCF |                |
| New Disability Certificate (OCF3) |         | New PAF Extension (OCF24) |               |                        |             |                 |          |                       |                |
| Accident ID                       | Form ID | Form Type                 | HCAI status   | Document Number        | Date        | Draft/Final     | Comments | Plan Number           | Invoice Number |
| 114                               | 132     | OCF18                     | Submit Errors |                        | 28-May-2010 | Draft           |          |                       | 1              |

Forms listed with Submit Errors will not be resubmitted until you resave them using the Save to HCAI button. It is therefore very important for users to monitor the report logs to ensure all forms are corrected and resubmitted.

## Error Report for HCAI Authorization/Provider Error

An authorization or provider error can be caused by one of four reasons:

### 1. Your Facility has not been approved

There may be an issue with the approval process. Confirm approval by accessing the HCAI website, [www.HCAI.ca](http://www.HCAI.ca). Click the **Manage** tab, followed by selecting the **Manage Facility** tab.

Under the **Facility Details** section check the **Status**.

The screenshot shows the 'Facility Details' section of the HCAI Facility Management interface. The 'Status' is 'Approved' and the 'Facility Number' is 42657. A red arrow points to the 'Status' field. The 'Facility Name' is 'PMP Department'. The 'Facility Start Date' is 20100514 and the 'Facility End Date' is 1123. The 'AISI Facility Number' is 1123. The 'Telephone' is (416) 860-4162 and the 'Fax' is (416) 860-0857. The 'Address Line 1' is 20 Victoria St, 'Address Line 2' is Mississauga, 'City' is Mississauga, 'Province' is ON - Ontario, and 'Postal Code' is M5C2V6.

### 2. Your Facility Number is listed wrong in PMP

The Facility Number that you input into the **Setup** menu, **Setup Facility** screen in PMP HCAI is incorrect.

The screenshot shows the 'Setup Facility Information' dialog box. The 'Facility Number' is 42657. The 'HCAI PMS User Name' is James. The 'HCAI User Name Password' field is empty. The 'Accept' button is at the bottom right.

Locate this information in the HCAI website, [www.HCAI.ca](http://www.HCAI.ca) on the **Manage, Manage Facility** tab.

**Facility Details**

Status: Approved  
 Facility Number: 42657  
 \* Facility Name: PMP Department  
 Corporation Number: [Empty Field]

Verify the **Facility Number**.

### 3. Your PMS User Name is listed wrong in PMP

The PMS User Name that you input into the **Setup** menu, **Setup Facility** screen in PMP HCAI is incorrect.

From the same HCAI screen listed above, scroll down to **HCAI Submission Method**.

**Setup Facility Information**

Facility Number: 42657  
 HCAI PMS User Name: James  
 HCAI User Name Password: [Empty Field]  
 You must type the password in once each session.  
 Accept

**HCAI Submission Method**

\* PMS Integration: ☐ No ☒ Yes  
 \* PMS Vendor: PMP  
 \* PMS User Name: James  
 RESET PASSWORD FOR PMS USER

Confirm your PMS User Name.

### 4. Your PMS Username Password is wrong

After 3 attempts in PMP HCAI to connect, go to the HCAI website, [www.HCAI.ca](http://www.HCAI.ca) on the **Manage, Manage Facility** tab. Scroll down to **HCAI Submission Method** and click **RESET PASSWORD FOR PMS USER**.

**HCAI Submission Method**

\* PMS Integration: ☐ No ☒ Yes  
 \* PMS Vendor: PMP  
 \* PMS User Name: James  
 RESET PASSWORD FOR PMS USER

**Please enter in your password**

Enter PMS Username Password:  
 QVpl6Tv3l  
 OK Cancel

Write the new password down.

**PMS User Name and Password Confirmation**

New HCAI user has been created. Username, password and link to HCAI should be given to users that did not provide a valid email address.

User Name: James  
 Password: DtYkGG8w  
 DONE

© 2009 Health Claims for Auto Insurance Processing | Privacy Policy | Change Password



## 5. You do not have the provider registered with HCAI or the practitioner information is incorrect

Check this information in the HCAI website, [www.HCAI.ca](http://www.HCAI.ca) on the **Manage, Manage Facility** tab. Scroll to the Associated Provider section at the bottom of the page.

**All providers** should be listed here. If they are not, click **Add Provider** and complete the required fields.

If the required practitioners are in the list, click individually on each and confirm that the information is correct.

| Associated Providers |            |          |          |
|----------------------|------------|----------|----------|
| (1 of 1)             |            |          |          |
| View: 10 items       |            |          |          |
| Provider Name        | Start Date | End Date | Status   |
| Palmer, Daniel       | 2010/05/14 |          | Approved |
| Pierce, Benjamin     | 2010/05/14 |          | Approved |
| Schweizer, Albert    | 2010/05/14 |          | Approved |
| Winchester, Charles  | 2010/05/14 |          | Approved |
| View: 10 items       |            |          |          |



PMP requires that Practitioners are listed with HCAI once for every profession.

I.E. if a practitioner is a Chiropractor and Acupuncturist they must be listed twice in the *Associated Provider* screen; once for each profession.

## Insurer List

The Insurer List will produce a report detailing all insurers and their branches. This list is updated every time you connect to HCAI.

## OCF Patient History

This report will produce a detailed report for the patient history of forms within PMP for a specific patient. You can filter the report further to show specified dates and whether Draft or Final.

OCF Patient History

Patient (the list only shows patients that have MVA accidents)

Lloyd, Alexander

☐ Filter by Form Date

Date From: Today

Date To: 01-Jan-2010

☐ Filter by Draft / Final

☐ Draft

☐ Final

☐ Show From/To on Report

Report Destination

☒ Screen ☐ Printer ☐ Export to RTF ☐ Save to File

Thu, 17 Mar 2011

**OCF Patient History**

Page No. 1

**Patient** 18  
Alexander Lloyd  
10 Pheasant Valley West, #605  
Downsview  
M3H 4Y2, ON

**Insurance Company** The Dominion of Canada General Insurance Company  
**Branch Name** Markham  
**Insurance Rep. Name** Frank Wright  
**Accident Date** 01-Apr-2010  
**Claim Number** 12345

**Policy Number** 54321  
**Policy Holder** Lloyd Barnabus

| Form ID | OCFx  | Draft | Form Date   | HCAI Status   | Comments |
|---------|-------|-------|-------------|---------------|----------|
| 131     | OCF18 | Draft | 06-May-2010 |               |          |
| 132     | OCF18 | Draft | 06-May-2010 | Submit Errors |          |
| 133     | OCF21 | Draft | 06-May-2010 |               |          |
| 134     | OCF18 | Draft | 14-Mar-2011 |               |          |

Message ID

| Date        | Time     | Document Number |
|-------------|----------|-----------------|
| 12-May-2010 | 10:30 am | 10051200003     |

**HCAI message:** E8FF4473-9906-4ABA-8A66-6115C729F73B

243 OCF21 Final 14-Mar-2011 Approved

Message ID

| Date        | Time     | Document Number |
|-------------|----------|-----------------|
| 14-Mar-2011 | 10:24 am | 11031400001     |
| 14-Mar-2011 | 11:24 am | 11031400001     |

**HCAI message:** D67E2EE8-63BD-4F63-BCFF-805B2BA00A77  
**HCAI message:** B3E1FB0D-066B-46BB-ADE6-DE9FC96FB2AE

## OCF Status Report

The OCF Status report will produce a list of forms that meet the filter options (criteria) selected. All forms created within PMP will be produced on the report if no filters are chosen.

The screenshot shows the 'OCF Forms status report' dialog box. It has a title bar with standard window controls. Below the title bar is a section titled 'Choose the optional filters to condense the report.' There are three main filter sections: 'Filter by HCAI Status' (checked), 'Filter by Form Date' (checked), and 'Filter by Draft / Final' (unchecked). The 'Filter by HCAI Status' section contains a list of checkboxes: (blank), InTransaction, Ready to Submit, Submitted, Submit Errors (checked), Approved, Partially Approved, Responded, and Declined. The 'Filter by Form Date' section has 'Date From' set to '01-Jan-2011' and 'Date To' set to '17-Mar-2011'. The 'Filter by Draft / Final' section has 'Draft' and 'Final' radio buttons. Below these is a 'Sort order' section with radio buttons for: order by Patient Name (selected), order by Patient Number, order by Doctor, Patient Name, order by Form Date, Patient Name, and order by Insurance Company, Patient Name. At the bottom is a 'Report Destination' section with radio buttons for: Screen (selected), Printer, Export to RTF, and Save to File. A 'Run the Report' button is located at the bottom right.

Filter options include:

- HCAI Status
- Form Date
- Draft / Final
- Sort Order

This report can be useful when looking forms that did not get submitted (Submit Errors).

This screenshot is identical to the one above, but with the 'Submitted' checkbox under 'Filter by HCAI Status' selected instead of 'Submit Errors'.

## Plan / Invoice Submission Log

This report details your interaction with HCAI. This report produces a message ID which can be used for troubleshooting with HCAI.

|                                    |                    |                         |      |         |       |             |  |              |                              |
|------------------------------------|--------------------|-------------------------|------|---------|-------|-------------|--|--------------|------------------------------|
| Thu, 17 Mar 2011                   |                    | OCF Forms Status report |      |         |       |             | Date From: 01-Mar-2011<br>Date To: 17-Mar-2011 |              | Page No. 1                   |
| Filtered by HCAI Status: Submitted |                    |                         |      |         |       |             |  |              |                              |
| Patient No                         | Patient Name       | Doc                     | OCFx | Form ID | Draft | HCAI Status | Form Date                                      | Claim Number | Insurance Company            |
| 13                                 | Greaves, Alexander | DD                      |      | 219     | Final | Submitted   | 11-Mar-2011                                    | 54545434     | PMSVendorSupport Insurance C |
| 13                                 | Greaves, Alexander | DD                      |      | 220     | Final | Submitted   | 11-Mar-2011                                    | 54545434     | PMSVendorSupport Insurance C |
| 770                                | Green, Geoffrey    | DD                      |      | 221     | Final | Submitted   | 11-Mar-2011                                    | r324324      | PMSVendorSupport Insurance C |
| 1500                               | Greer, Barbara     | DD                      |      | 222     | Final | Submitted   | 11-Mar-2011                                    | 544343       | PMSVendorSupport Insurance C |
| 54                                 | Low, Amy           | DD                      |      | 242     | Final | Submitted   | 14-Mar-2011                                    | 256          | Ascentus Insurance           |

## Facility Information

The facility information report details your facility details that are taken from the HCAI portal. It is updated every time you choose Connect to HCAI or **Get Facility Info** from the **Other** menu.

|  |                  |  |                  |                            |                   |                 |
|--|------------------|--|------------------|----------------------------|-------------------|-----------------|
| Thu, 27 May 2010   |                  | <b>Facility Information</b>            |                  |                            |                   | Page No. 1      |
| <b>Facility Name</b> PMP Department  |                  | <b>Authorizing Officer</b>             |                  |                            |                   |                 |
| <b>Facility ID</b> 426   |                  | <b>First Name</b> Lauren               |                  |                            |                   |                 |
| <b>Facility AISI Number</b>  |                  | <b>Last Name</b> James                 |                  |                            |                   |                 |
| <b>Facility Address</b>  |                  | <b>Title</b>                           |                  |                            |                   |                 |
| 20 Victoria St   |                  | <b>Telephone</b> 4168604162            |                  |                            |                   |                 |
| Mississauga ON   |                  | <b>Fax</b>                             |                  |                            |                   |                 |
| M5C2n8   |                  | <b>Email</b> ljames@chiropractic.on.ca |                  |                            |                   |                 |
|  |                  | <b>Contact One</b>                     |                  | <b>Contact Two</b>         |                   |                 |
|  |                  | <b>First Name</b> Liz                  |                  | <b>First Name</b>          |                   |                 |
| <b>Cheque Payable To</b> Lauren James  |                  | <b>Last Name</b> Pridham               |                  | <b>Last Name</b>           |                   |                 |
| <b>Lock Payable</b> False  |                  | <b>Title</b> Rep                       |                  | <b>Title</b>               |                   |                 |
|  |                  | <b>Telephone</b> 4168604163            |                  | <b>Telephone</b>           |                   |                 |
|  |                  | <b>Email</b>                           |                  | <b>Email</b>               |                   |                 |
| <b>Provider Listing</b>  |                  |  |                  |                            |                   |                 |
| <b>First Name</b>  | <b>Last Name</b> | <b>Provider ID *</b>                   | <b>College *</b> | <b>Registration Number</b> | <b>Start Date</b> | <b>End Date</b> |
| Daniel   | Palmer           | 17                                     | 1234             | DC                         | 14-May-10         |                 |
| Benjamin   | Pierce           | 18                                     | 2345             | DC                         | 14-May-10         |                 |
| Albert   | Schweizer        | 19                                     | J222             | MT                         | 14-May-10         |                 |
| Charles  | Winchester       | 20                                     | 5896             | DC                         | 14-May-10         |                 |
| <p>* You must make sure that you enter the Provider ID into PMP. It is found in Setup / Doctor Defaults / Edit MVA. This is used by PMP to bill HCAI appropriately. Similarly, please note the College Registration Number as it is used in several forms.</p> |                  |  |                  |                            |                   |                 |

## Automobile Insurance Activity in PMP

### Minor Injury Guideline (MIG)

**Note:** Full details regarding completing the **OCF23 – Treatment Plan** and **OCF21C Invoice** can be found by viewing a recording of the OCA Minor Injury Guideline- What Every Administrator Needs to Know webinar. This webinar can be viewed from **[www.chiropractic.on.ca](http://www.chiropractic.on.ca) \ PMP Website \ Training \ PMP Webinars.**

#### Outline

The objectives of the Minor Injury Guideline are to:

- a) Speed access to rehabilitation for persons who sustain minor injuries in auto accidents;
- b) Improve utilization of health care resources;
- c) Provide certainty around cost and payment for insurers and regulated health professionals; and
- d) Be more inclusive in providing immediate access to treatment without insurer approval for those persons with minor injuries as defined in the SABS and set out in Part 2 of this Guideline.

Consistent with these objectives, the Guideline sets out the goods and services that will be paid for by the insurer without insurer approval if provided to an insured person who has sustained a minor injury.

The Guideline is focused on the application of a **functional restoration approach**, in addition to the provision of interventions to reduce or manage pain or disability.

The full guideline is available for download from the Financial Services Commission of Ontario (FSCO) website, [www.fSCO.gov.on.ca/english/pubs/bulletins/autobulletins/2010/A-10\\_10-1.pdf](http://www.fSCO.gov.on.ca/english/pubs/bulletins/autobulletins/2010/A-10_10-1.pdf).

#### Fee Schedule Set up

MIG fees should be added to your PMP Fee Schedule.

Go to the **Setup** menu, **Fee Schedule, Treatment**. Click **Add, Form**.

| Code            | Description                  | OHIP Code     | OHIP Fee        |
|-----------------|------------------------------|---------------|-----------------|
| MIG1            | Minor Injury Block 1 (wk1-4) |               |                 |
| WSIB Code       | WSIB Fee                     | Adult         | Student         |
|                 |                              | 775.00        | 775.00          |
| Child           | No Charge                    | Senior        | Compassionate 1 |
| 775.00          | 775.00                       | 775.00        | 775.00          |
| Compassionate 2 | Compassionate 3              | Family member | MVA             |
| 775.00          | 775.00                       | 775.00        | 775.00          |
| Unused          | Unused                       | Unused        | Unused          |
|                 |                              |               |                 |
| Unused          |                              |               |                 |
|                 |                              |               |                 |

OK

Add all the items listed below. Use whatever code you wish, these are only suggestions.

|      |  |                              |
|------|--|------------------------------|
| MIGI | Minor Injury Initial Visit                       | 215.00                       |
| MIG1 | Minor Injury Treatment Phase Block 1             | 775.00                       |
| MIG2 | Minor Injury Treatment Phase Block 2             | 500.00                       |
| MIG3 | Minor Injury Treatment Phase Block 3             | 225.00                       |
| MIGD | Completion of Guideline Discharge Report (OCF24) | 85.00                        |
| MIGG | Minor Injury Goods & Services                    | 400.00 (this will be edited) |
| MIGT | Minor Injury Transfer Fee                        | 50.00                        |

**Note:** These Fees will not necessarily apply. The fees are being added so that you will know how much is billable for each completed block. Edit the amount to the correct total when processing activity.

### Posting Patient Activity

As your patient comes to each appointment, record the patient activity using your regular codes and fees for initial visits, adjustments and inventory items. Block fees should be posted after the initial visit and each block.

### Block Billing

Print the statement using the specific block dates for the start and end dates of the statement to enable you to figure out how much to bill for the block.

Wed, 5 Jan 2011

Blue Cross  
185 The West Mall  
Etobicoke ON M9C 5P1  
ATT: Stella Williams

ID # 1434  
Policy: 3445  
Claim: 50577505  
File

Patient : Lauren James  
5160 Explorer Drive, Unit 30  
Mississauga ON  
L4W 4T7

Last Statement : 05-Jan-2011  
Accident Date: 01-Oct-2010

**Statement of Account**  
From : 06-Oct-2010 to 05-Jan-2011

| Date        | Ref. Date | Doctor | Description     | OHIP/WSIB | Fee    | Payment | Balance |
|-------------|-----------|--------|-----------------|-----------|--------|---------|---------|
|             |           |        | BALANCE FORWARD |           |        |         | 215.00  |
| 06-Oct-2010 |           | DD     | Adjustment      |           | 35.00  |         | 250.00  |
| 08-Oct-2010 |           | DD     | Adjustment      |           | 35.00  |         | 285.00  |
| 11-Oct-2010 |           | DD     | Adjustment      |           | 35.00  |         | 320.00  |
| 13-Oct-2010 |           | DD     | Adjustment      |           | 35.00  |         | 355.00  |
| 15-Oct-2010 |           | DD     | Adjustment      |           | 35.00  |         | 390.00  |
| 18-Oct-2010 |           | DD     | Adjustment      |           | 35.00  |         | 425.00  |
| 20-Oct-2010 |           | DD     | Adjustment      |           | 35.00  |         | 460.00  |
| 22-Oct-2010 |           | DD     | Adjustment      |           | 35.00  |         | 495.00  |
| 25-Oct-2010 |           | DD     | Adjustment      |           | 35.00  |         | 530.00  |
| 27-Oct-2010 |           | DD     | Adjustment      |           | 35.00  |         | 565.00  |
|             |           |        |                 | 0.00      | 350.00 | 0.00    |         |

**BALANCE DUE: 05-Jan-2011 \$ 565.00**

The amount already posted to the patient's account (highlighted above in yellow) is deducted from the maximum billable amount for the MIG. For Block 1 this amount is \$775.00. Therefore in deducting the amount already billed, \$350.00 from the billable amount , \$775.00 you end up with an amount of \$425.00. This is the amount that is posted at the end of the block that will be billed to the auto insurer.

Here is the patient Account Activity screen after posting the Block 1.

| Date       | Ref. Date | Doc | Location | Code   | Bill Code | Type | Status | Paid by | Billing | Patient | Payment |
|------------|-----------|-----|----------|--------|-----------|------|--------|---------|---------|---------|---------|
| 05/10/2010 |           | DD  |          | 1 CE   |           | CASH | Paid   |         | 0.00    | 90.00   | 0.00    |
| 06/10/2010 |           | DD  |          | 1 A    |           | CASH | Paid   |         | 0.00    | 35.00   | 0.00    |
| 08/10/2010 |           | DD  |          | 1 A    |           | CASH | Paid   |         | 0.00    | 35.00   | 0.00    |
| 11/10/2010 |           | DD  |          | 1 A    |           | CASH | Paid   |         | 0.00    | 35.00   | 0.00    |
| 13/10/2010 |           | DD  |          | 1 A    |           | CASH | Paid   |         | 0.00    | 35.00   | 0.00    |
| 15/10/2010 |           | DD  |          | 1 A    |           | CASH | Paid   |         | 0.00    | 35.00   | 0.00    |
| 18/10/2010 |           | DD  |          | 1 A    |           | CASH | Paid   |         | 0.00    | 35.00   | 0.00    |
| 20/10/2010 |           | DD  |          | 1 A    |           | CASH | Paid   |         | 0.00    | 35.00   | 0.00    |
| 22/10/2010 |           | DD  |          | 1 A    |           | CASH | Paid   |         | 0.00    | 35.00   | 0.00    |
| 25/10/2010 |           | DD  |          | 1 A    |           | CASH | Paid   |         | 0.00    | 35.00   | 0.00    |
| 27/10/2010 |           | DD  |          | 1 A    |           | CASH | Paid   |         | 0.00    | 35.00   | 0.00    |
| 27/10/2010 |           | DD  |          | 1 MIG1 |           | CASH | Paid   |         | 0.00    | 425.00  | 0.00    |

**Hint:** If EHC does not pay 100% of the treatment cost, the amount not paid will be billed on the OCF 21 invoice, not in PMP.

Here is the completed statement showing the Initial visit and the Block 1 amount for the auto insurer.

Wed, 5 Jan 2011

Blue Cross  
185 The West Mall  
Etobicoke ON M9C 5P1  
ATT: Stella Williams

ID #: 1434  
Policy: 3445  
Claim: 58577585  
File

Patient: Lauren James  
5160 Explorer Drive, Unit 30  
Mississauga ON  
L4W 4T7

Last Statement: 05-Jan-2011  
Accident Date: 01-Oct-2010

Statement of Account  
From: 01-Oct-2010 to 05-Jan-2011

| Date        | Ref. Date | Doctor | Description                  | OHIP/WSIB | Fee    | Payment | Balance |
|-------------|-----------|--------|------------------------------|-----------|--------|---------|---------|
|             |           |        | BALANCE FORWARD              |           |        |         | 0.00    |
| 04-Oct-2010 |           | DD     | Minor Injury - Initial Visit |           | 125.00 |         | 125.00  |
| 05-Oct-2010 |           | DD     | Consultation/Examination     |           | 90.00  |         | 215.00  |
| 06-Oct-2010 |           | DD     | Adjustment                   |           | 35.00  |         | 250.00  |
| 08-Oct-2010 |           | DD     | Adjustment                   |           | 35.00  |         | 285.00  |
| 11-Oct-2010 |           | DD     | Adjustment                   |           | 35.00  |         | 320.00  |
| 13-Oct-2010 |           | DD     | Adjustment                   |           | 35.00  |         | 355.00  |
| 15-Oct-2010 |           | DD     | Adjustment                   |           | 35.00  |         | 390.00  |
| 18-Oct-2010 |           | DD     | Adjustment                   |           | 35.00  |         | 425.00  |
| 20-Oct-2010 |           | DD     | Adjustment                   |           | 35.00  |         | 460.00  |
| 22-Oct-2010 |           | DD     | Adjustment                   |           | 35.00  |         | 495.00  |
| 25-Oct-2010 |           | DD     | Adjustment                   |           | 35.00  |         | 530.00  |
| 27-Oct-2010 |           | DD     | Adjustment                   |           | 35.00  |         | 565.00  |
| 27-Oct-2010 |           | DD     | Minor Injury Block 1 (wk1-4) |           | 425.00 |         | 990.00  |
|             |           |        |                              | 0.00      | 990.00 | 0.00    |         |

BALANCE DUE: 05-Jan-2011 \$ 990.00

## Tracking Sheets

These forms have been designed to assist with tracking the office visits for your Motor Vehicle Accident patients. Full page copies can be found at the end of this guide. An electronic copy is available by contacting support.

**MIG Tracking Sheet.** Record the initial visit date and the date range for blocks when your patient begins care. This form should be attached to the front of the patient file or attached to the travel card so you have it readily available. Fill in the boxes with the actual dates of treatment as your patient attends their office visits. As you complete the form, you can tell at a glance the status of the MIG.

| MIG                       |  | TRACKING SHEET |  |  |  |  |          |
|---------------------------|--|----------------|--|--|--|--|----------|
| NAME:                     |  |                |  |  |  |  |          |
| START DATE:               |  |                |  |  |  |  |          |
| APPROVAL DATE:            |  |                |  |  |  |  |          |
| Initial Visit             |  |                |  |  |  |  | \$215.00 |
| Block 1                   |  |                |  |  |  |  |          |
|                           |  |                |  |  |  |  |          |
|                           |  |                |  |  |  |  | \$775.00 |
| SUBMISSION DATE:          |  |                |  |  |  |  |          |
| Block 2                   |  |                |  |  |  |  |          |
|                           |  |                |  |  |  |  | \$500.00 |
| SUBMISSION DATE:          |  |                |  |  |  |  |          |
| Block 3                   |  |                |  |  |  |  |          |
|                           |  |                |  |  |  |  | \$225.00 |
| SUBMISSION DATE:          |  |                |  |  |  |  |          |
| Goods & Services          |  |                |  |  |  |  | \$400.00 |
| OCF-24 STATUS & DISCHARGE |  |                |  |  |  |  | \$85.00  |

**The Treatment Plan Tracking Form** will help you to recognize at a glance when it is time to submit new treatment plans for MVA patients who do not qualify for pre-approved framework.

Mark the tracking form to indicate the number of treatments covered by your Treatment Plan by highlighting the correct number of boxes or by putting brackets around them. When your patient attends their office visits, record the actual dates of treatment in the boxes. If you are treating your patient twice a week and know it will take two weeks to get approval for a new Treatment Plan, you need to submit an extension request when the patient has six visits left.

| TREATMENT PLAN TRACKING FORM |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
|------------------------------|-----------|----------------|--|--|--|--|--|--|--|--|--|--|--|--|
| NAME:                        |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| START DATE:                  |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| APPROVAL DATE:               |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| CHIRO                        |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
|                              |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
|                              |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
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|                              |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
|                              |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
|                              |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| PHYSIO                       |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
|                              |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
|                              |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
|                              |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| RMT                          |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
|                              |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| TREATMENT PLAN               |           | TREATMENT COST |  |  |  |  |  |  |  |  |  |  |  |  |
|                              | TX PLAN # | TX PLAN #      |  |  |  |  |  |  |  |  |  |  |  |  |
| CHIRO                        |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| PHYSIO                       |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| RMT                          |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| SENT                         |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| APPROVED                     |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| CHIRO                        |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| PHYSIO                       |           |                |  |  |  |  |  |  |  |  |  |  |  |  |
| RMT                          |           |                |  |  |  |  |  |  |  |  |  |  |  |  |

MIG

TRACKING SHEET

NAME: \_\_\_\_\_

START DATE: \_\_\_\_\_

APPROVAL DATE: \_\_\_\_\_

Initial Visit

\$215.00

Block 1

\$775.00

SUBMISSION DATE: \_\_\_\_\_

Block 2

\$500.00

SUBMISSION DATE: \_\_\_\_\_

Block 3

\$225.00

SUBMISSION DATE: \_\_\_\_\_

Goods & Services

\$400.00

OCF-24 STATUS & DISCHARGE

\$85.00



## TREATMENT PLAN TRACKING FORM

NAME: \_\_\_\_\_

START DATE: \_\_\_\_\_

APPROVAL DATE: \_\_\_\_\_

CHIRO

|  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
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PHYSIO

|  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |

RMT

|  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |

## TREATMENT PLAN

|          | TX PLAN # _____ |      | TX PLAN # _____ |      |
|----------|-----------------|------|-----------------|------|
|          | Visits          | Cost | Visits          | Cost |
| CHIRO    |                 |      |                 |      |
| PHYSIO   |                 |      |                 |      |
| RMT      |                 |      |                 |      |
| SENT     |                 |      |                 |      |
| APPROVED |                 |      |                 |      |